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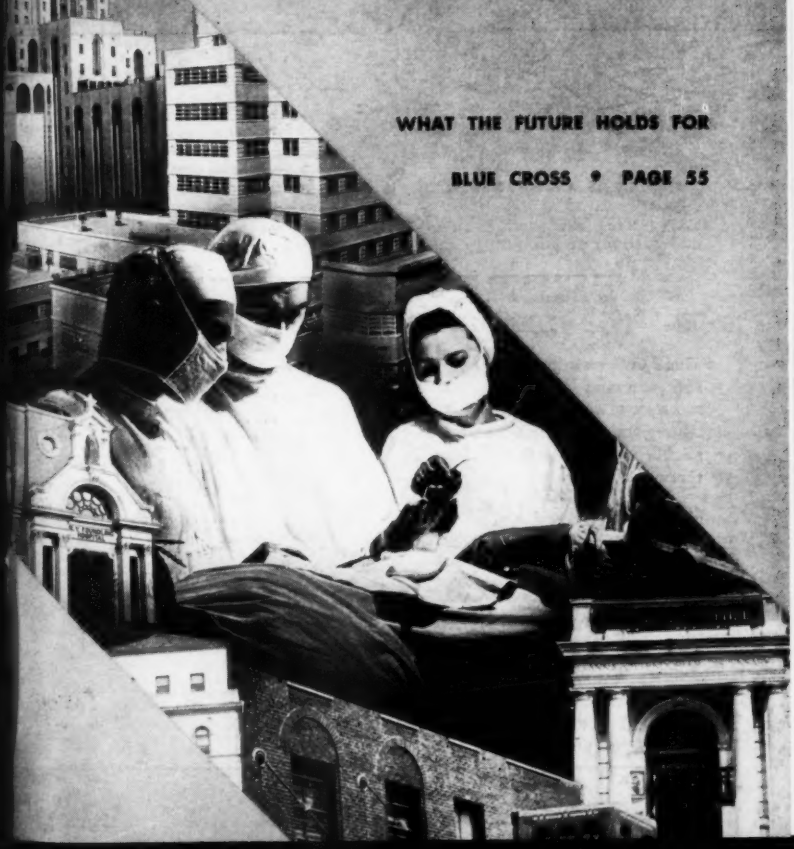
Medical Economics

MARCH

WHAT THE FUTURE HOLDS FOR BLUE CROSS • PAGE 55



vitamin preparations are either supplementary or therapeutic

You can't expect a boy to do a man's job...nor can you expect a supplementary multivitamin preparation to restore tissue levels in frank deficiency states.

THERA-CONCEMIN

THERAPEUTIC VITAMIN CAPSULES

Thera-Concemin presents the basic and practical *therapeutic* formula recommended by Jolliffe,* containing the essential fat- and water-soluble vitamins at levels 3 to 5 times normal daily requirements.

Dosage: Two capsules daily for a week or ten days, followed by one capsule daily until tissue levels of the essential vitamins are restored to normal.

Each capsule contains:

Vitamin A	25,000 U. S. P. units
Vitamin D	1,000 U. S. P. units
Thiamine hydrochloride	5 milligrams
Riboflavin	5 milligrams
Niacinamide	150 milligrams
Ascorbic acid	150 milligrams

*Jolliffe, N.: The Preventive and Therapeutic Use of Vitamins, J.A.M.A. *129*:613-617 (1945).

THERA-CONCEMIN IS AVAILABLE IN BOTTLES OF 30 CAPSULES

MERRELL
1828

Trademark "Thera-Concemin"

THE WM. S. MERRELL COMPANY • CINCINNATI, U. S. A.

Medical Economics

MARCH 1947

H. Sheridan Baketel, M.D., Editor-in-Chief. William Alan Richardson, Editor. Edmund R. Beckwith, Jr. and R. Cragin Lewis, Associate Editors. Lansing Chapman, Publisher. W. L. Chapman, Jr., Business Manager. R. M. Smith, Sales Manager.

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IN EAR EXAMINATION AND OPERATION

PLASTIC SPECULA, thin, strong, non-reflecting. Easily sterilized.

ROTATING SPECULUM MOUNT . . . 36% larger operative field.

TONGUE DEPRESSOR HOLDER

BRILLIANT ILLUMINATION, concentrated at speculum opening.

ROTATING MAGNIFIER . . . 2½ magnification, giving sharp focus at orifice of speculum.

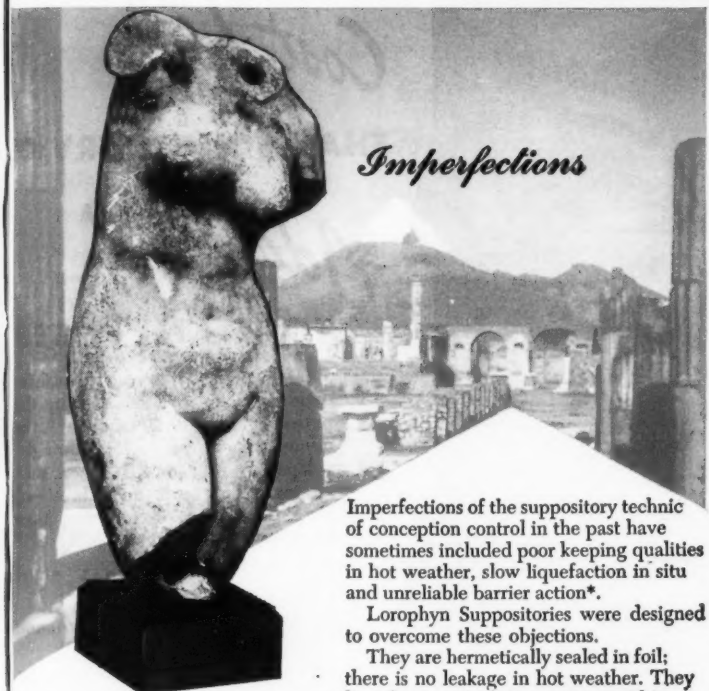
LIGHT WEIGHT . . . total head weight is less than two ounces.

ARC-VUE PRISM OTOSCOPE

The purpose of medical equipment is to simplify your examining and operating procedure. The Bausch & Lomb Arc-Vue Otoscope does just that, by being so adaptable that you can do everything the natural, easy way. Now again in stock at your surgical supply dealer's. Bausch & Lomb Optical Co., Rochester 2, N. Y.

BAUSCH & LOMB

ESTABLISHED 1853



Torso of statue, ca. 4th Cent. B.C. found in Rome. Courtesy Metropolitan Museum of Art.

Imperfections

Imperfections of the suppository technic of conception control in the past have sometimes included poor keeping qualities in hot weather, slow liquefaction in situ and unreliable barrier action*.

Lorophyn Suppositories were designed to overcome these objections.

They are hermetically sealed in foil; there is no leakage in hot weather. They liquefy at vaginal temperature within fifteen minutes, liberating the powerful spermicide, phenylmercuric acetate. They are self-emulsifying in vaginal fluids to form a tenacious and persistent spermicidal barrier.

LOROPHYN SUPPOSITORIES

A method of conception control that patients will use faithfully.

When a jelly is preferred, we suggest

LOROPHYN JELLY

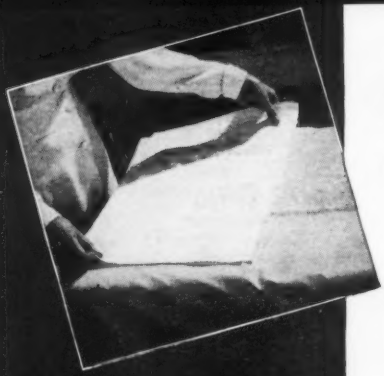
Rapidly spermicidal, with demonstrated barrier action.

Phenylmercuric acetate 0.05%, Polyethylene glycol of mono-iso-octyl-phenyl ether 0.3%, Methyl p-hydroxy benzoate 0.05%, Sodium borate 3.0% in a special jelly base.

Phenylmercuric acetate 0.05% and glyceryl laurate 10.% in a water-dispersible wax base.

EATON LABORATORIES Inc.
NORWICH, NEW YORK

*Dickinson, R. L., Techniques of Conception Control, Williams & Wilkins Co., Baltimore, 1942.



Cost Less

THAN TOWEL SERVICE

Adaptable

TO MANY USES

J & J Professional Towels provide individual service appreciated by the patient. Made with "Masslinn*", the unique non-woven cotton fabric developed by Johnson & Johnson, they are amazingly soft and absorbent. Economical too—use once, then throw away—no laundry bills.

TYPICAL PROFESSIONAL USES:

- *Hand Towel.*
- *On examining tables and instrument trays.*
- *Wiping instruments after use.*
- *Wrapping instruments for sterilization.*
- *To remove ointments or pastes.*
- *To protect patients' clothing during eye, ear, nose or throat work.*
- *On baby scales.*
- *Beneath arm during phlebotomy.*
- *Colostomy dressings.*

ORDER FROM YOUR DEALER

Johnson & Johnson
NEW BRUNSWICK, N. J. CHICAGO, ILL.

DISPOSABLE

PROFESSIONAL TOWELS

*Trade-mark

Panorama

► Committee for the Nation's Health, pressure group for compulsory health insurance, has increased its membership from 200 to 2,000, says Dr. Channing Frothingham, and has members in forty-seven states . . . More than 3,000 Veterans Administration hospital beds were empty in a recent month because of lack of personnel to service them . . . New York Times says a London specialist sent a lawyer a bill for £6 for two consultations and got a bill in return, worded as follows: "For time wasted in appointments which were never kept, due to non-arrival of doctor, £8."

► New edition of U.S. Pharmacopœia has dropped 7 per cent tincture of iodine in favor of 2 per cent . . . Applicants for appointment as surgeons in Public Health Service must be at least 21 years of age, a PHS release announces . . . Dr. Stephen Taylor, Member of Parliament, tells his Laborite constituents that the test of a good doctor is, "Does he make you take your shirt off when he examines you?" . . . Movie Actress Joan Crawford was slapped recently with a $200,000 damage suit alleging invasion of privacy because, it was said, she witnessed shock treatment of a woman in a Pasadena hospital without the patient's consent . . . Arkansas is training 1,500 midwives (most of them between 60 and 80) in modern methods of child delivery.

► A study of heart disease mortality rates by occupation shows only barbers and bartenders worse off than doctors . . . Honeymooners and other couples seeking a secluded vacation can get a private suite and meals without cost in a London hospital in exchange for their services as guinea pigs in research on the common cold . . . Having played the radio role of "Doctor Christian" for ten years, Jean Hersholt has the next best thing to a diploma: a letter of praise from Dr. Morris Fishbein for giving the public "a better understanding of the family doctor" . . . Newspapers warned thief who stole $2,500 worth of radium from the car of Dr. Edward Markey Pullen of New York that he might be carrying a radioactive death warrant in his pocket.

why Dexedrine is so beneficial in menstrual dysfunction

"The Central Nervous Stimulant of Choice"

Dexedrine therapy not only alleviates the mental depression and psychogenic fatigue which ordinarily accompany dysmenorrhea; but also, through its marked amelioration of mood, beneficially alters the patient's reaction to pain.
Smith, Kline & French Laboratories, Philadelphia, Pa.

Dexedrine Sulfate **tablets**

(dextro-amphetamine sulfate, S.K.F.)

▶ Tired of jibes about his long ears, Romano Pandolfi of Rome, Italy, trimmed them with a razor, spent the next month in a hospital . . . Eight county medical societies in western New York have formed a coordinating council to present a united front in safeguarding public welfare and rights of doctors. Five county medical societies of New York City already had such a council. Still other blocs are expected . . . Presidents of more than 900 colleges have been invited to attend the third annual conference on health in colleges, to be held in New York, May 7-10 . . . Technical exhibits arranged by manufacturers at conventions should be aimed at the general practitioner, not the specialist, declares Dr. L. F. Foster, secretary of the Michigan State Medical Society.

▶ President Truman may be in favor of compulsory sickness insurance, but it won't make much difference after 1948 if present opinion of voters means anything. In a Gallup poll, only 9 per cent thought the Democrats would win the next Presidential election, 79 per cent picked the Republicans, 12 per cent had no opinion . . . American Press, a trade journal, polled 1,000 rural newspaper editors, found 80 per cent opposed to compulsory health insurance, 12 per cent for it, 8 per cent undecided . . . V.A. has been scanning the job applications of osteopaths, having been virtually directed by the Seventy-ninth Congress to engage some for its Department of Medicine and Surgery . . . Likelihood of a continuing glass bottle shortage has prompted the drug industry to ask for an informal priority system so public health won't suffer.

▶ New cancer clinic for children, at New York's Memorial Hospital, is said to be first of its kind. It's a component of the system established by Strang Foundation. Not widely known as a children's disease, cancer in 1944 caused 3 per cent of deaths in children of 5 to 14. "It caused more deaths among youngsters than diphtheria, measles, polio, acute rheumatic fever, or diabetes," says Metropolitan Life . . . "The California Rhythm Doctors," an orchestra formed by members of the Alameda County (Calif.) Medical Society, is seeking new talent. "If you can do hot licks on a slipstick, beat out boogie on a dog-house, or glide a glissando on a glockenspiel—you're in!" it says . . . Confined to his hotel room by an attack of indigestion, Dr. Morris Fishbein still made the papers by addressing a meeting of the Springfield (Mass.) Academy of Medicine over a public address system set up at his bedside . . . Sister Kenny fund drive now has theme song: "Rolling Coins on Parade."

peristalsis

"Liquid bulk" produced in the gut by the osmotic action of SAL HEPATICA tends to stimulate the normal peristaltic wave to laxation or catharsis.

The desired action of this balanced saline can be easily controlled by the physician through proper regulation of dosage. Speedy, thorough action throughout the entire canal.

SAL HEPATICA

A professional product of

BRISTOL-MYERS COMPANY, 19 WEST 50th STREET, NEW YORK 20, N. Y.

MANDELAMINE

.Reg. U. S. Pat. Off.
(Methenamine Mandelate)

IS AN ESPECIALLY EFFECTIVE URINARY ANTISEPTIC

Safety, ease of administration, and characteristically prompt action combine to make Mandelamine an especially efficient agent in the treatment of urinary infections in children and in elderly patients.

Freedom from drug toxicity is an important consideration to the busy physician who is unable to maintain patients under close medical supervision. Mandelamine may be confidently prescribed in therapeutic dosage virtually without consideration of toxic effects.

Uncomplicated oral administration of Mandelamine requires no supplementary acidification, restriction of fluid intake, dietary control, or other special measures. Only in those infections due to urea-splitting organisms, may accessory acidification be necessary.

Early control of common urinary infections is the characteristic response to Mandelamine therapy. Disturbing urinary symptoms are usually alleviated rapidly and, in the absence of obstruction, the urine is promptly cleared of organisms in a high percentage of cases.

Mandelamine is supplied in enteric coated tablets of 0.25 Gm. (3¾ grains) each, in packages of 120 tablets sanitaped, and in bottles of 500 and 1000.

NEPERA CHEMICAL CO. INC,
21 Gray Oaks Ave.
Yonkers 2, New York
Please send me literature, and a physician's sample of Mandelamine.

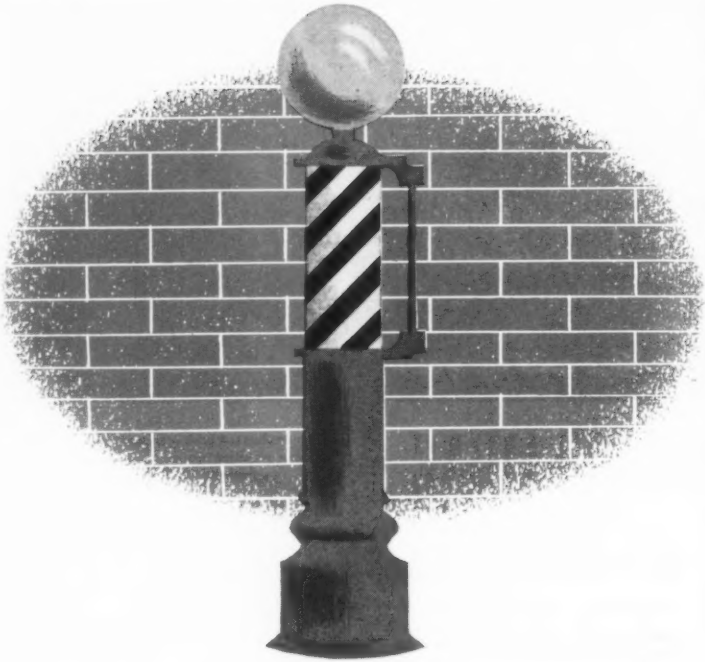
Name.....M.D.

Street.....

City.....State.....

NEPERA CHEMICAL CO. INC.

Manufacturing Chemists **Yonkers 2, New York**



DO YOU KNOW WHAT THESE SYMBOLS

Rexall

DRUGS

Rexall for Reliability

S STAND FOR?

The barber pole is a relic of the middle ages, when barbers professed also to be surgeons and dentists. The pole was originally a red staff, wrapped with removable bandages, hung with dental instruments and topped by a brass lathering bowl.

The familiar blue and white Rexall sign is a modern symbol of superior and dependable pharmacal service. There are more than 10,000 independent, reliable drug stores, conveniently located throughout the country, which display this sign. It assures you of drugs laboratory-checked for purity, potency and uniformity under the rigid Rexall system of controls—and of selected pharmacal ability in compounding them.

REXALL DRUG COMPANY

LOS ANGELES, CALIFORNIA

Pharmaceutical chemists for more than 44 years

TO HELP YOU PRESCRIBE BALANCED INFANT DIETS

All the Meat, All the Vegetables a Baby Requires are Combined in These New Soups

5 nutritious food combinations, scientifically formulated, ready to feed

Here, in single glass jars, are five appetizing "main dishes" for a baby's meals. Fed regularly, they can be relied upon to furnish in nutritional balance all the meat and all the vegetables required for normal healthy growth. Four of these new soups contain meat—chicken, lamb, beef, or liver (beef)—combined with different vegetables and a cereal. The fifth, a vegetable soup, combines eight vegetables and oatmeal.

Prepared for maximum food values and greatest palatability

In developing these new soups, Campbell's found that maximum retention of vitamins and minerals went hand-in-hand with retention of wholesome ingredient flavors. Consequently, in manufacturing, every step is undertaken to safeguard both food values and food flavors. Many unsolicited letters from Mothers attest that these soups are outstandingly good to eat.

The trend in modern nutrition is toward combination foods

Government statistics show the use of combination foods in infant feeding is increasing rapidly. Here are three primary reasons why more and more doctors prescribe them. (1) They help substantially in providing the well-rounded mixed diet a baby needs. (2) Every spoonful contains scientifically worked-out combinations of nourishing foods, in accurate proportions. (3) The presence of all the meat and vegetables for a whole meal in a single glass jar greatly facilitates feeding, and saves time for busy mothers. These combination foods may be started as early as any strained foods. For more details, write: Campbell Soup Company, Camden, N. J.

Every grocer who sells Campbell's Soups can supply Campbell's Baby Soups

Campbell's STRAINED **BABY SOUPS**

LOOK FOR THE RED-AND-WHITE LABEL

Speaking Frankly

Lowdown

Your February article, "The Political Make-up of the American Medical Association," gives the lowdown on the high-ups that we rank-and-filers have been waiting for. Do you have more installments coming? If so, I suggest for your scrutiny some of the wheelhorses in the House of Delegates.

M.D., New Jersey

Part 2 of the series appears in this issue; more installments are coming, including one on the delegates. Suggestions from readers are welcomed.

Blast

I'm tired of hearing about state medicine. Why is the profession so jittery? Fully 35 per cent are already practicing "state medicine," if you include all health officers, insurance and industrial doctors, state and city hospital staffs, V.A. physicians, and salaried men in the big specialty clinics. How much independence do these practitioners have?

The men making the biggest squawk about state medicine are the high-priced specialists who do most of the exploiting. They take 80 cents of the patient's dollar and leave 20 cents for the family doctor —who does most of the work.

I have worked in state institutions, so I have an intimate acquaintance with the evils of political medicine. But that does not blind me to the fact that we have just as great evils in our present set-up.

C. McNeely, M.D.
Blackfoot, Idaho

Salaried physicians in this country are still a long way from state medicine. They can quit and go into private practice.

Refugees

Shame on you for reporting that news story about refugee doctors in your January issue! Why add disgrace to the plight of refugee doctors? The majority of physicians who escaped Hitler's persecution live in New York. Many of them are members of the New York County Medical Society, where they are admitted without citizenship. But every one of them will be proud to become a citizen as soon as he has completed his required five years of residence in the U.S. Generalizations such as that made by the Allegheny County (Pa.) Medical Society about "unethical refugees" are vicious acts of prejudice.

M.D., New York

Most county societies in New York State, and certainly ours, are taking in foreign-born physicians as members. They must have filed their first papers, thereby certifying their intention of becoming citizens within five years. Each one is put through the same careful processing

...py in otologic infections

1. Effective in BOTH acute AND chronic otitis media.
2. Has enhanced antibacterial potency.
3. Diffuses more completely into infected tissues.
4. Effects micro-debridement by chemical action on necrotic tissues.
5. Promotes effective local analgesia—without impaired sulfonamide activity.
6. Is free from unphysiologic alkalinity or distressing side actions.
7. Rapidly controls noxious odor of purulent discharge.

White's Otomide is composed of 5% Sulfanilamide, 10% Urea (Carbamide) and 3% Anhydrous Chlorobutanol in a specially processed glycerin vehicle of unusually high hygroscopic activity.

Supplied in dropper bottles of ½ fluid ounce (15 cc.)

Strakosch, E. A. and Clark, W. G.: Minn. Med., *26*:276-282 (Mar.) 1943.
Tsuchiya, H. M. et al.: Proc. Soc. Exp. Biol. and Med., *50*:262-266 (June) 1942.
McClintock, L. A.; Goodale, R. H.: U. S. Naval Med. Bull., *41*:1057-1064 (July) 1943.
Mertins, P. S. Jr.: Arch. Otolaryng., *26*:509-513 (Nov.) 1937.
Ashley, R. E.: Trans. Am. Acad. Ophth. and Otolaryng., *46*:257-264 (July-Aug.) 1942.

White's **otomide**

that all applicants for membership undergo.

Our membership committee makes a personal investigation in each case. After approval by this committee, the applicant's name is published twice before he is elected to membership.

James E. Bryan
Executive Secretary
Medical Society of the
County of New York

Scream

With the V.A., the state hospitals, and the public screaming for more psychiatrists, the American Board of Psychiatry and Neurology goes its antiquated way. All applicants, it insists, must have more than five years of N.P. experience. It examines in a hasty, one-day oral, and flunks 60 per cent of the candidates. That leaves the dumb flunkees the glorious opportunity of being state hospital paupers or low-grade V.A. pariahs.

Is there a psychiatrist in the house to examine the psychiatrists?

M.D., California

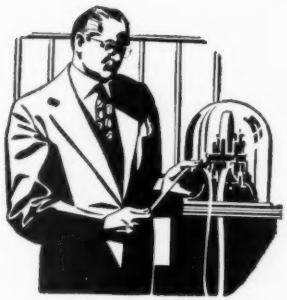
$tudy

Our medical schools are busy teaching us how to help everyone but ourselves. Result: The young M.D. is turned loose among the wolves before his business eye-teeth are cut.

In my first year of practice, I was offered a home-office for $4,000. I didn't have the money and didn't know my credit was good. So I waited—and later paid $12,000 for the same property.

It was years before I learned that in my state I had to file a claim against a deceased patient's estate to collect a medical bill. That, too,

Financial Wizard . . . . . .



Dietary Dub!

He may not be one of your patients, but you know his dietary counterparts: Men —and women—too deeply immersed in "important" affairs to take time to eat properly. With them, scanty breakfasts and hasty, badly balanced lunches are the rule; dinners which fail to compensate for the defects of earlier meals, far from uncommon. The inevitable result is an increase in the ranks of the self-made victims of borderline vitamin deficiency. You know them: the ignorant and indifferent, food faddists, persons on self-imposed and badly balanced reducing diets, alcoholics, excessive smokers and many others. • You know, too, that since the bodily reserves of the vitamin B complex group are not large, even in patients whose diets are good, the more frequent results are deficiencies of the B factors. • This is one of the three important reasons why we think you will wish to know about SUR-BEX, a pleasant tasting, high potency vitamin B complex tablet. An even more important consideration is that Sur-bex contains *all* of the B complex factors in therapeutic amounts. The third reason is the availability of Sur-bex to your patients through pharmacies everywhere. Bottles of 100, 500 and 1,000. Remember the name, SUR-BEX. ABBOTT LABORATORIES, North Chicago, Illinois.

Sur-bex
TRADE MARK

EACH TABLET CONTAINS:
Thiamine Hydrochloride, 6 mg.; Riboflavin, 6 mg.;
Nicotinamide, 30 mg.; Pyridoxine Hydrochloride, 1 mg.;
Pantothenic Acid (as calcium pantothenate), 10 mg.;
Liver Concentrate,* 5 grs.;
and Brewer's Yeast, Dried,* 2½ grs.
**For other B complex factors.*

cost me plenty of money.

I suggest that at least an hour a month during medical school be devoted to "How to Make a Living."

M.D., Pennsylvania

Osteopaths

I was graduated from both an approved medical school and a college of osteopathy. In the one concept in which osteopathy differs from medicine—*i.e.*, the mechanical cause of disease—the D.O.'s are wrong. Most of them know they are wrong. But on the other side of the ledger is the fact that many of our licensed doctors of medicine are as ignorant and as poorly schooled as the worst of the osteopaths.

F. L. R. Roberts, M.D.
Spirit Lake, Iowa

Collecting

Can you tell me, from past research done by your valuable magazine, the average percentage of bills collected by physicians?

Kenneth Blanchard, M.D.
East Orange, N.J.

The Fifth MEDICAL ECONOMICS *Survey (for 1943) showed that U.S. physicians, on the average, collected 87 per cent of their accounts. In 1939 they averaged 78 per cent; in 1935, 74 per cent.*

Recheck

In your December issue, James F. Bender says that "syndrome" is pronounced "SIN droh mi." Stedman's Medical Dictionary gives it two syllables, accent on the first.

Charlotte M. Frost
Wichita, Kan.

Says Mr. Bender: "'SIN drohm' is commonly heard; but the classical pronunciation calls for three syllables."

Maybe we lean over backward—

But it pays off in safer SAFTIFLASK SOLUTIONS

Frankly, "production" says we're overdoing it on Saftiflask Solutions. Testing them, that is.

But just try and talk our testing experts into taking anybody's work for granted! Not those boys. They've got to be *shown!**

And what they do to Saftiflask Solutions—could only happen in a biological laboratory. Fact is, our *being* a biological lab is the main reason they're so fussy. They're so grooved to being picky with Cutter serums and vaccines—they just can't help "throwing the book" at Saftiflask Solutions.

Add to such safety the convenience of Saftiflask technic—and even your harassed staff will take time to thank you!

But—seeing is believing—so why not call your Cutter representative for a demonstration?

**And occasionally, in spite of all our pains, they rule out a lot which could have given your patients trouble.*

CUTTER LABORATORIES

Berkeley, California • Chicago • New York

Banker

I have my secretary open a bank account in the name of each new baby I deliver. A deposit of one dollar is made while the mother is still in the hospital; then the bank book is mailed to her with a cheerful greeting.

A grateful mother wrote, "I would never have thought of opening an account for Tommy. Now his father deposits a small sum each week."

Simple though it is, the plan has worked wonders in patient relations.

M.D., Massachusetts

Shutout

Thousands of G.P.'s want graduate training in a specialty. But the long-term graduate courses seem to go only to men whose interneships have recently been completed or whose residencies were interrupted by the war. How about a movement to provide more graduate education for the G.P.?

M.D., Pennsylvania

Turnabout

What to charge nurses for medical service is a controversial issue in my town. Many nurses have left their profession and have become housewives. Do they still rate a professional discount?

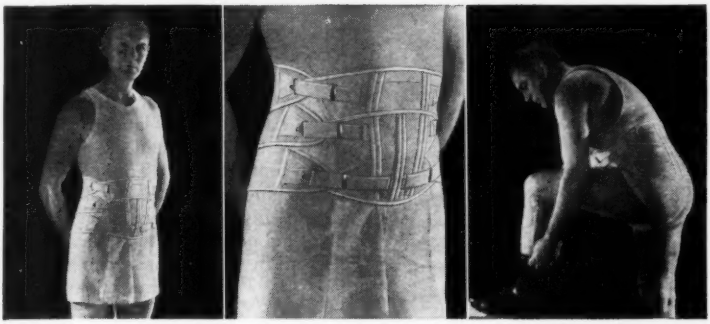
If a doctor becomes ill and needs special nursing care, it's a cinch that he doesn't get it gratis. Yet many nurses apparently expect free treatment from their physician.

M.D., Massachusetts

Treatment

Recently I was ordered to a V.A. clinic for treatment. I reported on time and was assigned to a physician I had never seen before. I had

ANNOUNCING
THE SPENCERFLEX FOR MEN



Individually designed for each patient, the Spencerflex provides pelvic control and abdominal uplift with freedom for muscular action. Improves posture and body mechanics at work or play or during convalescence. Non-elastic. Will not yield or slip under strain. Very durable, moderate cost. Can be put on, removed, or adjusted in a moment.

Also designed as adjunct to treatment following upper abdominal surgery (center, above). Especially indicated where drainage has been maintained for a considerable period. Completely covers and protects scar without "digging in" at lower ribs. Relieves fatigue and strain on tissues and muscles of wound area. ***We know of no other support for men providing these benefits.***

For information about Spencer Supports, telephone your local "Spencer corsetiere" or "Spencer Support Shop", or send coupon at right.

MAY WE SEND YOU BOOKLET?

SPENCER, INCORPORATED
131 Derby Ave., Dept. ME, New Haven 7, Conn.
In Canada: Rock Island, Quebec.
In England: Spencer (Banbury) Ltd., Banbury, Oxon.

Please send me booklet, "How Spencer Supports Aid The Doctor's Treatment."

Name ..... M.D.

Street .....

City & State 3-47

SPENCER *INDIVIDUALLY DESIGNED* SUPPORTS
Reg. U. S. Pat. Off.
FOR ABDOMEN, BACK AND BREASTS

trouble understanding the doctor and he had difficulty in hearing me. I almost had to shout when I gave him my history (which he didn't take down). Later he placed a stethoscope to my chest. It was purely an act because he was deaf.

That was my general examination.

From there, I went to another physician for a specialty examination. The second man started out in a novel way by throwing the ashes from his cigar at a wastepaper basket. They landed all over my vest. All this man's actions were non-professional. There was a twitching about his shoulders and head; his speech was irregular.

I am now going to a private physician in whom I have confidence.

Veteran, Connecticut

Nutrition

Thanks for your January article, "Nutrition: a Sub-Specialty for the G.P." Knowledge of nutrition is mounting rapidly. Meanwhile, popular interest in dietary matters is being fanned by the faddists.

Now is the time for the G.P. to get up-to-date by postgraduate study in nutrition. As you pointed out in your article, many good courses are now available.

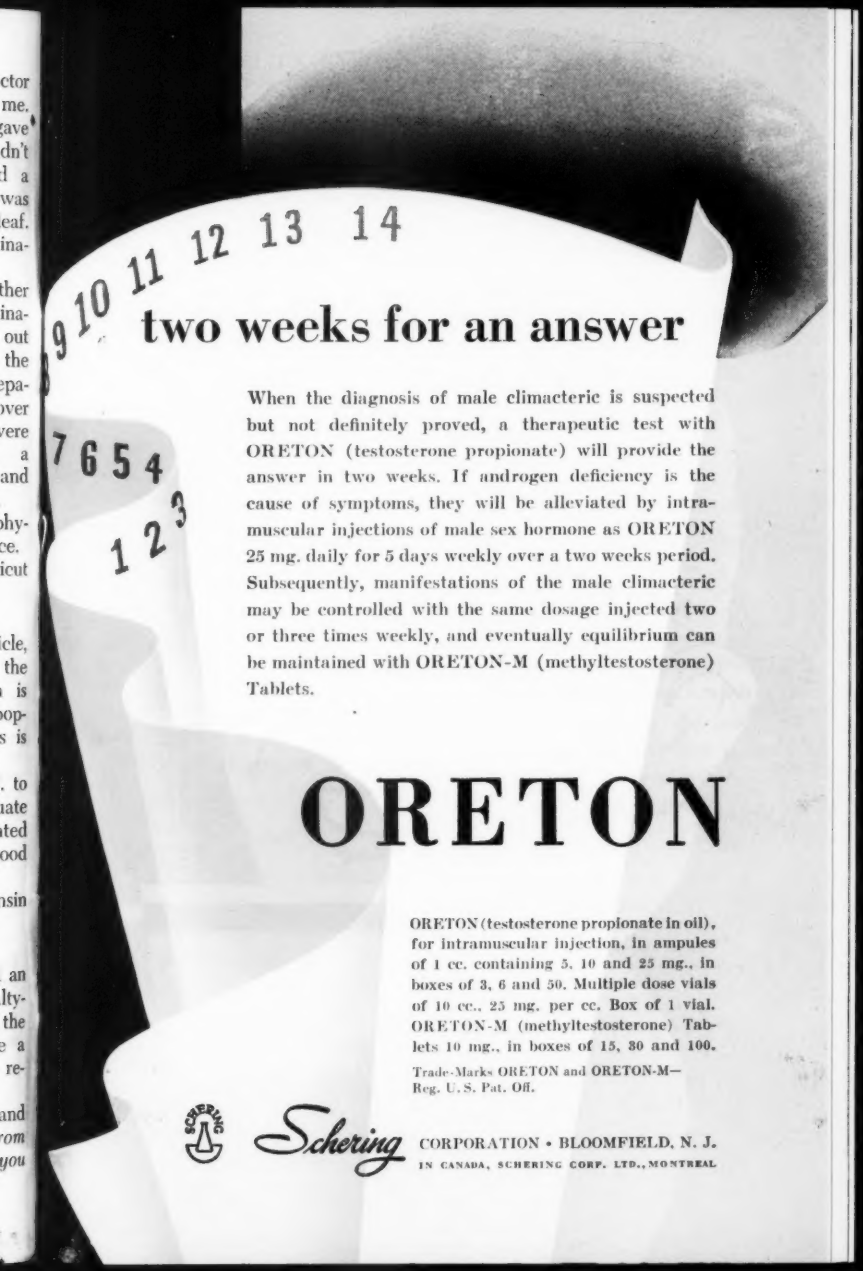
M.D., Wisconsin

Credit

In a recent issue you carried an article on how to obtain specialty-board credit for time spent in the armed forces. Please send me a form on which to report the required data.

M.D., Rhode Island

Forms must be obtained from the specialty board in which you are interested.


9 10 11 12 13 14
two weeks for an answer
When the diagnosis of male climacteric is suspected but not definitely proved, a therapeutic test with ORETON (testosterone propionate) will provide the answer in two weeks. If androgen deficiency is the cause of symptoms, they will be alleviated by intramuscular injections of male sex hormone as ORETON 25 mg. daily for 5 days weekly over a two weeks period. Subsequently, manifestations of the male climacteric may be controlled with the same dosage injected two or three times weekly, and eventually equilibrium can be maintained with ORETON-M (methyltestosterone) Tablets.
7 6 5 4
1 2 3
ORETON
ORETON (testosterone propionate in oil), for intramuscular injection, in ampules of 1 cc. containing 5, 10 and 25 mg., in boxes of 3, 6 and 50. Multiple dose vials of 10 cc., 25 mg. per cc. Box of 1 vial. ORETON-M (methyltestosterone) Tablets 10 mg., in boxes of 15, 30 and 100.
Trade-Marks ORETON and ORETON-M—Reg. U.S. Pat. Off.
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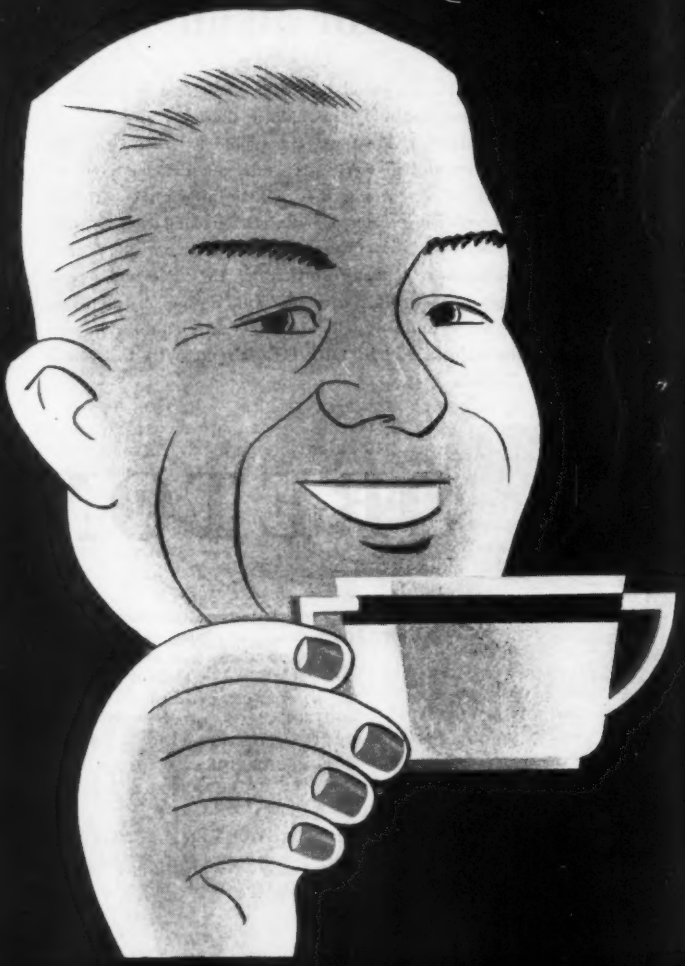
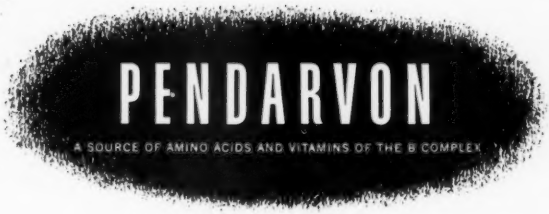
Schering CORPORATION • BLOOMFIELD, N. J.
IN CANADA, SCHERING CORP. LTD., MONTREAL

Supplement the protein intake



with well-balanced and palatable



EMPLOYING enzymatic hydrolysates of yeast, casein, and lactalbumin, with added *dl*-methionine plus effective amounts of vitamins of the B complex, Pendarvon meets the clinical requirements of completeness and balance in an amino acid preparation. Rational amounts of the B complex vitamins, closely associated metabolically with amino acids,* are also provided.

YES, IT'S PALATABLE

The pleasant taste and ease of administration of Pendarvon are outstanding. It is presented in the form of *porous* granules, which disperse instantly and dissolve completely in hot water to form a clear, tasty bouillon. If desired, Pendarvon may be taken without further preparation followed by water or other liquid.

INDICATIONS:

Protein loss: **burns, draining abscesses, diarrhea;** ***increased protein requirements:*** **pregnancy, lactation, hyperthyroidism;** ***impaired protein ingestion or digestion:*** **pre- and post-operatively, gastrointestinal diseases;** ***other deficiencies:*** **anemia and B avitaminoses, and hepatitis.**

HOW SUPPLIED:

8-oz. bottles.

Let us send you a trial supply for tasting.

*Ruskin, S. L.: The Role of the Coenzymes of the B Complex Vitamins and Amino Acids in Muscle Metabolism and Balanced Nutrition, Amer. J. Dig. Dis., 13:110-122 (April) 1946.

Pendarvon is the registered trademark of Nutrition Research Laboratories.

NUTRITION RESEARCH LABORATORIES • CHICAGO

RAY-FORMOSIL

FOR THE TREATMENT OF

ARTHRITIS and RHEUMATISM

73% BENEFITED

In one series of clinic-treated cases of atrophic, hypertrophic and mixed arthritis—with best results in hypertrophic and fibrositic types.

Ray-Formosil for intramuscular injection is a clinically proved, effective treatment in most cases of Arthritis and Rheumatism. It is a non-toxic and sterile, buffered solution containing in each cc. the equivalent of:

Formic Acid ..... *5 mg.*
Hydrated Silicic Acid ..... *2.25 mg.*

Descriptive clinical literature will be furnished upon request.

If your dealer cannot supply you, order direct. 1 cc. Ampuls—12 for $3.50; 25 for $6.25; 100 for $20.00.

A Quarter Century Serving Physicians

RAYMER PHARMACAL COMPANY

PHARMACEUTICAL MANUFACTURERS, PHILADELPHIA 34, PA.

Presenting

TWO FAMILIAR COMPOUNDS—
COMBINED TO WORK TOGETHER

Neo-Synephrine* *with* Penicillin

FOR VASOCONSTRICTION AND ANTIBACTERIAL EFFECT IN ACUTE AND CHRONIC SINUSITIS

Neo-Synephrine . . .	outstanding among vasoconstrictors—in a new solution . . . especially prepared and *buffered* for use with penicillin.
Penicillin	"the best of the antibacterial drugs we now have for the local treatment of chronic sinus . . . infections"[1]
In a Combination Package	containing one vial each of dried calcium penicillin and specially buffered Neo-Synephrine Hydrochloride Solution ¼% . . . to be mixed just prior to dispensing. When mixed, each cc. contains not less than 1000 units of penicillin at pH 6.0.
Special Buffer Action	holds the pH at 6.0—optimal pH for maximum stability of penicillin in solution . . . physiologically approximating the slightly acid pH of normal, healthy nasal secretions.
For Use	in the treatment of acute and chronic sinusitis, by displacement, irrigation or tampon . . . full strength or diluted with one part normal saline.
Supplied	as combination package containing one vial each of dried calcium penicillin (approximately 15,000 units) and specially buffered Neo-Synephrine Hydrochloride Solution ¼% (15 cc.). Available on prescription only.

Trial supply upon request

Frederick Stearns & Company
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New York • Kansas City • San Francisco • Atlanta • Windsor, Ontario
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[1] Ann. Otol., Rhin. & Laryng. 52:541, 1943.

*Neo-Synephrine is the registered trade-mark of Stearns brand of Phenylephrine.

Unexcelled SEEING!

THE BURTON FRESNEL
3 in 1 Medical Light

NOW INCORPORATING THE HIGH QUALITIES AND STANDARDS OF POST-WAR PRODUCTION

Never before a light like this! Never before advantages like these offered physicians by the versatile BURTON Fresnel Medical Light.

- Lowest-priced all-purpose light on the market.
- 3 great lights in 1—triple illumination for diagnostic, operative and examination work.
- Over 1000 foot-candles of heat-free, color-corrected true 'white' light for your office.
- Easy finger-tip control to adjust angles, vary light fields or light intensity.
- Beautiful bakelite construction; impressive modern design.
- Standard 100-wt. bulb; no transformers or rheostats required; operates from any 110-volt line.

The BURTON Fresnel 3 in 1 Medical Light is available now through your dealer. Write today for full information.

No. 1200A — Desk Model & Microscope Lamp
Dark and bright field; monocular or binocular. Lighting head detachable for easy mounting on floor stand. Filters available. Price, Complete $14.75

No. 1204A—Gooseneck Model
12 in. of heavy-duty black-crackle, flexible "gooseneck." Adjustable from 42½ to 64 in. Price, Complete $22.75

AVAILABLE IN 5 MODELS

No. 1201A—Floorstand Model
Adjustable, 41½ to 64½ in. Black crackle finish, polish trim. Balanced base. Lighting head tips to any angle. Price, Complete $22.75

No. 1202A—Wall Model
(Not illustrated) Attractive telescoping bracket extends to 25½ in. Takes little space when not in use. Price, Complete $22.75

No. 1201A-S—("Shortie") Floorstand Model
(Not illustrated) Same as No. 1201A Floorstand Model excepting height. Adjustable from 30½ to 52 in. Price Complete $22.75

AS A SPOTLIGHT | AS A FLOODLIGHT | FOR DIFFUSED LIGHT

BURTON — SCIENTIFIC INSTRUMENTS — PROFESSIONAL EQUIPMENT

BURTON
MANUFACTURING COMPANY
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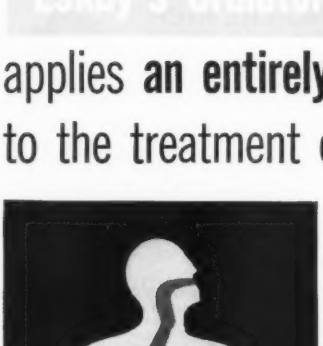
A revolutionary advance in the treatment of cough . . .

Eskay's Oralator, an oral inhaler, applies an entirely new principle to the treatment of cough.

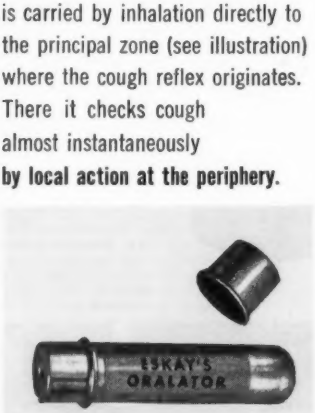


The Oralator contains a remarkable new anesthetic-analgesic compound—2-amino-6-methylheptane, S.K.F. The vapor of this compound is carried by inhalation directly to the principal zone (see illustration) where the cough reflex originates. There it checks cough almost instantaneously **by local action at the periphery.**

The effectiveness of

Eskay's Oralator

has been established by extensive clinical trials. 77% of the patients were benefited.



Smith, Kline & French Laboratories, Philadelphia, Pa.

Sidelights

"What a difference from that indrawn, cold-fish sourpuss, Senator Robert A. Taft!" says the left-leaning journalist, Albert Deutsch, writing about the Ohio Senator's younger brother. We think it's about time to separate politics and personalities in this instance. To reporters more interested in facts than in fancy, Senator Taft has always appeared friendly, loquacious, and approachable. We mention this in the hope of exploding what is a notion among some doctors and a fearfully mixed metaphor: the vision of medicine's torch being carried by a human icicle.

Figuring out new schemes to part physicians from their money is to some people, apparently, an irresistible pastime. But it takes two to make a bargain, even a bad one. If a report from a Better Business Bureau friend of ours is any indication, now is hardly the time to undertake adventures in capitalism without sound business advice.

Our informant quotes a few horrible examples:

"A group of doctors in my state purchased a well-known 'hot spot.' The deal looked like a good speculation, and a couple of these doctors could sometimes be seen proudly holding down ringside tables in their new enterprise. But they paid altogether too much for the place. Today I learned that this would-be Stork Club has folded, leaving the doctors holding the bag.

"Another M.D. group I know of bought a mineral spring. It's a going business, worth maybe $25,000. But when these physicians showed up, imbued with rosy enthusiasm and $80,000, that's what it cost them. It will take sagacious management to salvage their investment.

"The same physicians also took a flyer on a printing plant. Their type of therapy has failed to show anything but a weekly loss of about $1,200. They also bought a toy business. It may work out, but the toy business is highly competitive, highly seasonal.

"Physicians like these have seen a lot of money made by their business friends in recent years. They can't understand why they should see red when they open the ledger on their own business ventures. They apparently don't know that Better Business Bureaus are still reporting plenty of 'takes' by slick operators specializing in the medical profession.

"The antidote is often just a little more looking and a little less leaping. Plus the counsel of a reputable businessman."

If you're ever driven to the curb by the wail of an ambulance siren

in New Jersey, you can pass a pleasant quarter-minute reflecting that it may be the vehicle serving Dr. James G. Greene of Passaic. Doctor Greene's engraved announcements of the recent gala opening of his Main Dog and Cat Hospital will not soon be forgotten. Featured attractions are boarding, bathing, and clipping of small animals—and, as an added attraction, ambulance service. Of his neighborhood M.D., Doctor Greene may well say, "What's *he* got that *I* haven't got?"

In a sheaf of grisly headlines, the public press has wrapped up the medical misdemeanors of Nazi physicians and gone on to fresher crimes. Before the weird graftings and transplantings pass into oblivion, though, two aftermaths are worth adding to the medical record.

British doctors have worked themselves into a high glow debating whether the full results of Nazi experiments should be published. We're inclined to side with the hard-headed scientific minds on this one. What's done is done; and it's just possible that reading *how* it was done might add something to useful medical knowledge. Dr. Kenneth Mellanby, whom the British Medical Association assigned to look into the matter, scoffs at arguments against publishing the results as "pernicious sentimentality."

Physicians in this country are more likely to linger over the moral overtones of Nazi medical crimes. Specifically, what made German doctors topple from medicine's high ethical plane? Did their servility to the state under socialized medicine

[PLEASE TURN TO PAGE 36]

PRE-CAUTION

Hemorrhage is a constant challenge to the physician and surgeon. Not only in the control . . . the duration . . . but also in the volume of blood loss.

KOAGAMIN*, by injection offers rapid assistance by reducing the clotting time of blood.

Literature and bibliography on request.

Chatham

CHATHAM PHARMACEUTICALS, INC.
NEWARK 2, NEW JERSEY, U. S. A.

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have anything to do with it?"

With the war over, it's probably too late to dig a pat answer out of the rubble. But some telling spadework is on display in a recent issue of the Journal of American Insurance, which cites a few German medical atrocities "to call attention to the fact that there is a great deal more to the practice of medicine than the scientific knowledge required." Says the journal: "No one can be more dangerous than the educated man who has lost his sense of responsibility and his ethical standards. If there really is any possibility that adoption of a system of state medicine could result in even a fraction of such degeneration in the American medical profession, the subject is worthy of very close scrutiny."

A local physician blew into our editorial offices recently under a fine head of steam. "What do you mean," he demanded of our awestruck receptionist, "by printing articles that favor things like compulsory health insurance and osteopathy? And how about these articles criticizing AMA policies, sometimes even individual doctors? Whose side are you on, anyway?"

It's just possible that our receptionist, whom we didn't hire for her agility in public debate, was unable to cope with the situation. We have a hunch that our irate visitor got away with his safety valve still untripped. If so, we consider it one of the most-missed opportunities of the month, for there's actually no question about whose side we are on or about what our editorial policy is.

MEDICAL ECONOMICS is against

You say when, Doctor! Then, mothers will find Gerber's Chopped Foods (vegetables, fruits, meat-combinations, desserts) make it simple to satisfy the growing appetites of growing babies.

Take meats, for instance. Gerber's are finely diced for easy chewing—combined with succulent chopped vegetables. Pre-cooked by steam under pressure (like *all* Gerber Foods) to retain minerals and vitamins to a high degree.

Here's another specialty of Gerber's Chopped Foods—the one-serving container. Same size, same *high* quality, same *low* price as Gerber's Strained Foods. This makes the transition from Strained to Chopped Foods easier! And baby gets more variety—without leftovers.

Yes, Gerber's work hand-in-hand with mothers and doctors everywhere because we agree that "Babies are the most important people."

Send for samples of Gerber's Chopped Apples and professional reference cards. Write to Gerber's, Dept. 223-7, Fremont, Michigan.

Gerber's

Fremont, Mich.—Oakland, Calif.

Baby Foods

3 Cereals
13 Chopped Foods
18 Strained Foods

state medicine. It is against unqualified practitioners. It is for organized medicine. It is for the individual physician.

So far, no surprises.

It does occasionally surprise some doctors, however, to learn that MEDICAL ECONOMICS is independently owned and published. Specifically, that means its editorial policy is independent of both its advertisers and the AMA. No publication worth its salt would fail to take advantage of that position by seizing every chance for unbiased appraisal and evaluation and by reporting both sides of controversial questions.

This vantage point seems all the more worth protecting when one thinks about the other medical periodicals. The Journal AMA, for example, could scarcely print both the good and the bad about AMA actions. The state medical society journals and the official specialty journals are also limited in what they can say. Nor could an organ of a pharmaceutical house be expected to point resolutely to imperfections in the present system of medical care. The way we look at it, MEDICAL ECONOMICS' job is to help the doctor, both individually and collectively. And helping him isn't always accomplished by tossing bouquets.

Not all physicians see eye to eye with us on what we publish. So we're glad to give space to those who hold divergent views. Minorities ought to be heard, and they often are in these pages.

As for our friend with the skyrocketing blood pressure, if he did not, as we suspect, get the answer he should have gotten from our receptionist, this is it.

MOIST HEAT THERAPY

IN conditions which require Moist Heat applications—but no specialized nursing care—an ANTIPHLOGISTINE poultice is indicated.

This ready-to-use medicated poultice is applied comfortably hot directly to the affected area. It maintains Moist Heat for many hours.

The comforting Moist Heat of an ANTIPHLOGISTINE pack is effective in relieving the pain, swelling, and muscle spasms due to sprains, strains and contusions.

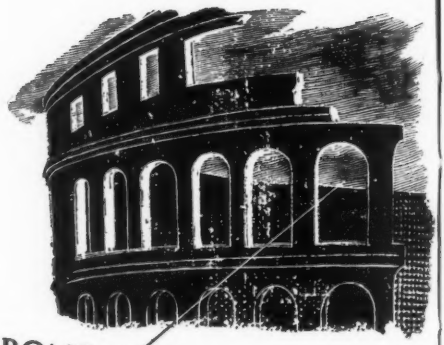
It is likewise effective in affections of the respiratory system; in relieving the cough, soreness, tightness of the chest, muscular and pleuritic pain.

ANTIPHLOGISTINE may be used with chemo-therapy.

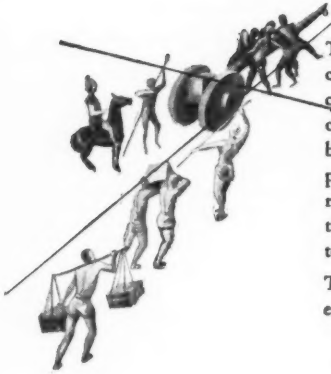
Formula: Chemically pure Glycerine 45.000%, Iodine 0.01%, Boric Acid 0.1%, Salicylic Acid 0.02%, Oil of Wintergreen 0.002%, Oil of Peppermint 0.002%, Oil of Eucalyptus 0.002%, Kaolin Dehydrated 54.864%.

THE DENVER CHEMICAL MFG. CO., INC.
New York 13, N. Y.

Antiphlogistine



WAS ROME BUILT IN A DAY?



The answer to this time-worn question, as everyone knows, is NO. The same holds true if the question concerns recovery from hemorrhoidal disorders. The acute symptoms may be quickly relieved but regression of the local pathology is a longer process. To foster complete recovery in hemorrhoidal disorders, local treatment should be continued for three to four weeks after the acute symptoms have been relieved.

The patient's cooperation throughout treatment is easily obtained with—

'ANUSOL'

***Anusol Hemorrhoidal Suppositories are safely used for prolonged treatment because they contain no narcotic, no anesthetic, no analgesic, no hemostatic. Anusol does not mask serious pathology. There are no systemic by-effects.* * *Reg. U. S. Pat. Off.*

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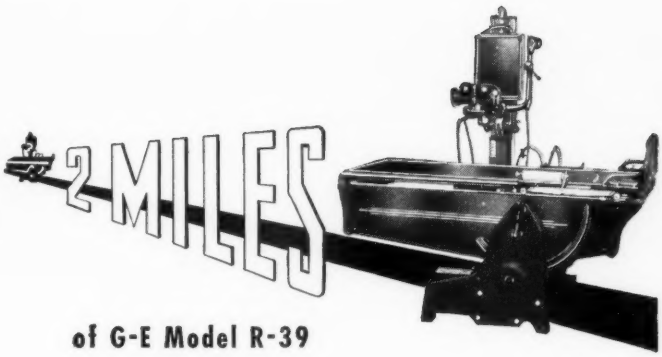
WILLIAM R. WARNER & CO., INC.
113 WEST 18th STREET, NEW YORK 11, N. Y.



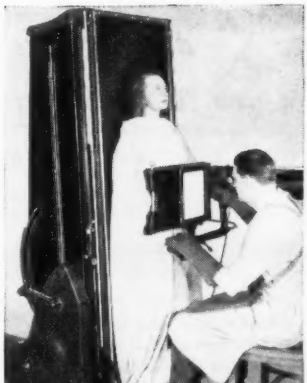
of G-E Model R-39 X-Ray Units Now in Service!

If you can picture in your mind's eye a two-mile column of R-39 Units, placed end to end, you'll have a good idea of the popularity of this particular model, and the vast amount of diagnostic service it is rendering daily in the offices of specialists, and in clinics and hospitals everywhere.

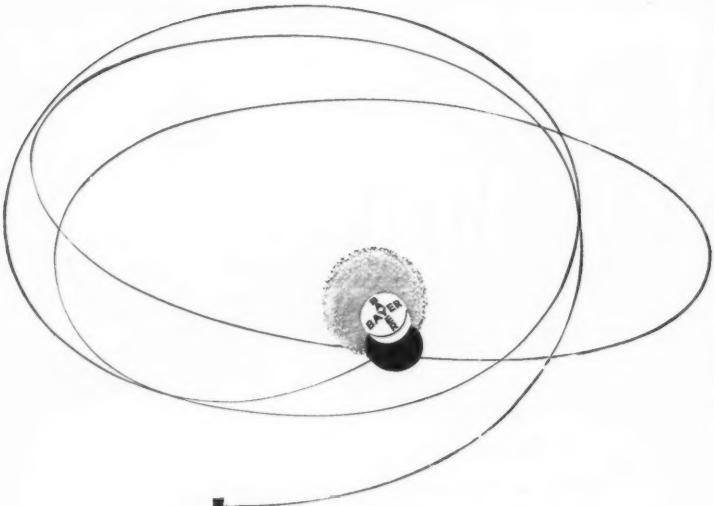
Why the R-39's great popularity?

1. It is an all-round diagnostic unit, yet is so compactly designed that it can be accommodated in a small floor space.
2. Has ample power (100 ma. and 85 kvp) for general radiographic and fluoroscopic diagnosis.
3. Its unusual flexibility facilitates positioning of the patient vertically, angularly, or horizontally.
4. Its double-focus genuine Coolidge tube serves both over and under the table.
5. The simple-to-operate, refined control system assures a consistently fine quality of work.

You, too, may find the Model R-39 ideally adaptable to your particular needs. Why not investigate, by writing today for complete information. Address Dept. 2616, General Electric X-Ray Corporation, 175 W. Jackson Blvd., Chicago 4, Ill.



GENERAL ELECTRIC X-RAY CORPORATION



In a single year
doctors have written from
ten to twelve million prescriptions
*containing Aspirin**

The Bayer Laboratories at Rennselaer, New York, have specialized in the making of Aspirin for over 46 years.

To insure the quality, purity, uniformity and quick disintegration of Bayer Aspirin, seventy different tests and inspections are used.

BAYER *Aspirin*

*Estimate of a leading authority on pharmacy after a survey of thousands of prescriptions.

Experience is the Best Teacher

Sir Charles Bell

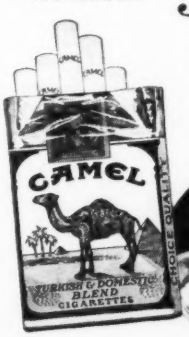
(1774-1842)

proved it in Neurology

After years of research and experiment, Sir Charles Bell explained the human nervous system as he saw it. His greatest discovery is known as Bell's law: That the anterior spinal nerve roots are motor and the posterior spinal roots are sensory. The stubborn searching necessary to establish his findings proves — *experience is the best teacher.*

Yes, and experience is the best teacher in smoking too!

R. J. Reynolds Tobacco Co.
Winston-Salem, N. C.

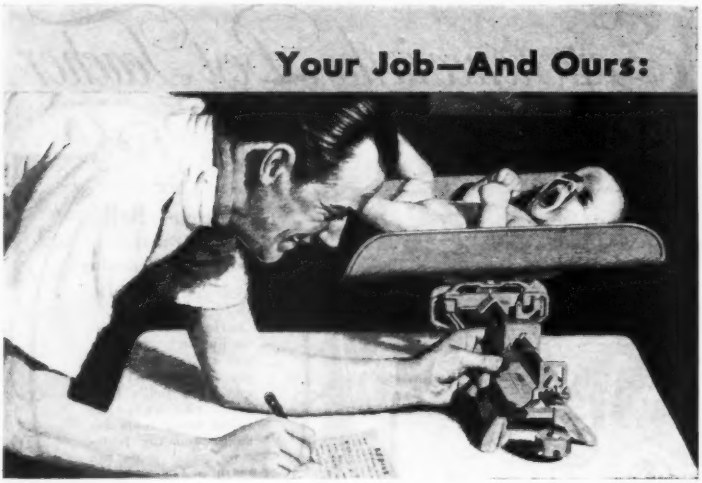


THE wartime cigarette shortage is only a memory now, but that's when millions — smoking any brand they could get — learned the differences in cigarette quality. And, significantly, more people are smoking Camels than ever before in history. But, no matter how great the demand: ***Camel quality is not to be tampered with. Only choice tobaccos, properly aged, and blended in the time-honored Camel way, are used in Camels.***

According to a recent Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette



To Build Baby's Weight

We're glad to share a little of that responsibility, and proud of our record in helping babies to a fine start in life with Nestlé's Evaporated Milk. We're also glad to promise that you'll always be able to place full confidence in Nestlé's.

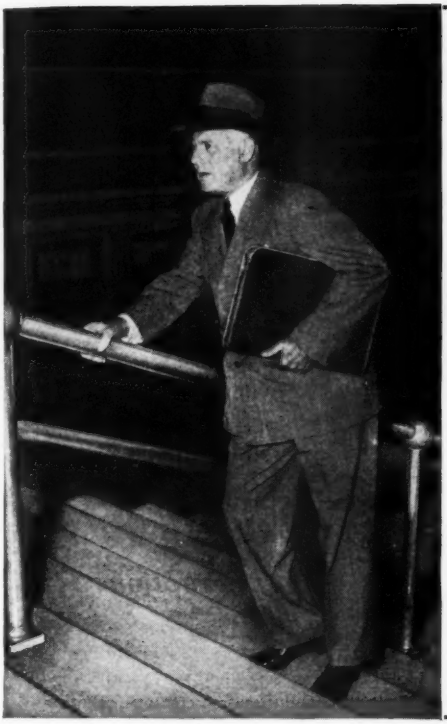
NESTLÉ'S

NESTLÉ'S MILK PRODUCTS, INC.
New York, U. S. A.

Nestlé's Has the "Know-How" to Produce a Good Product

- For 75 years, Nestlé's milk products have been best known, most used for babies 'round the world.
- Nestlé's was the *first* evaporated milk to be fortified with 400 USP units of genuine Vitamin D_3 per pint.
- Nestlé's accepts milk only from carefully inspected herds. As further assurance of quality, rigid controls check Nestlé's Milk every step of the way. We even take the plant apart every day and wash it!

No wonder so many doctors recommend NESTLÉ'S Milk by name



ANGINA PECTORIS

and other Manifestations of CORONARY INSUFFICIENCY

The following episodes may be prevented by appropriately regulated administration of a vasodilator having a *sustained* effect:

FOR THE PERSON

- *who is compelled to stop and rest when climbing a flight of stairs.*
- *who suffers "indigestion" and "gas" on exertion, or after a heavy meal.*
- *who is stricken with precordial pain on unusual exertion or emotion, or when exposed to cold.*

The vasodilatation produced by Erythrol Tetranitrate Merck begins 15 to 20 minutes after administration, and lasts from 3 to 4 hours.

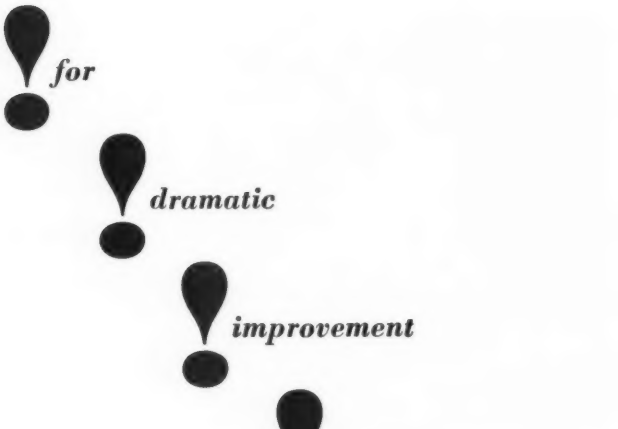
It is generally agreed that the acute attack of anginal pain is most readily relieved by the prompt removal of the provocative factor, and by the use of nitrites. For prophylactic purposes—to control anticipated paroxysms—the delayed but prolonged action *of erythrol tetranitrate is effective. Erythrol tetranitrate, because of its slower* and more prolonged *action, is also considered preferable for the purpose of preventing nocturnal attacks.*

ERYTHROL TETRANITRATE
MERCK
(ERYTHRITYL TETRANITRATE)

Council *Accepted*

MERCK & CO., Inc. RAHWAY, NEW JERSEY
Manufacturing Chemists

MERCK MERCK



In the troublesome and commonly encountered eczematous eruptions and particularly in those involving a seborrheic factor, Pragmatar will often bring dramatic improvement.

Perhaps the most convincing evidence of the unusual effectiveness of this outstanding tar-sulfur-salicylic acid ointment is its widespread acceptance by dermatologists, and the impressive success with which it met the exacting demands of wartime military use in every climate and under every adverse condition.

Pragmatar (with sulfur and salicylic acid)

highly effective in an unusually wide range of common skin disorders

Smith, Kline & French Laboratories, *Philadelphia, Pa.*

Editorial

Trial by Depression

All too familiar is the boom-crash-boom pattern of business. Less familiar is the close tie between economic depression and public susceptibility to compulsory sickness insurance.

People under financial stress are traditionally receptive to government aid. The early days of the Roosevelt Administration, with its farflung CCC and WPA, illustrate how quickly government can step into the breach when the people want it to. Economic hardship creates a public mood for state medicine—and for the political candidates who promise it.

It seems reasonable to suppose, then, that the next depression will constitute an acid test for private medicine.

Before stocks tumble and belts tighten, an answer must be found to the public demand for wider distribution of medical care and for spacing its cost. Voluntary health insurance must be extended to the more than 1,000 U.S. counties not now covered by any medical society plan. Prepaid medical care must be sold to a substantial proportion of the 95 million eligible persons not now enrolled.

Preventive medicine, public health, child care, and medical research all need expansion. Nor can we blink the trouble spots in our system. Unless medicine in rural communities and in mining districts, for example, is revitalized, physicians can expect these areas to turn into hotbeds for state medicine. A depression can be counted on to add fuel to the flame.

The constructive planks in medicine's platform are well known. Not enough attention has been paid to the deadline for nailing these planks into place.

When will the next depression come? It's anyone's guess. But the slump usually arrives sooner than the experts predict.

To fortify our system of private medical care before the country's economy takes its next header is only good sense.

Our trial by depression is now in the making.

—H. SHERIDAN BAKETEL, M.D.

Broader Background Sought for Physician of the Future

Premedical education, enjoying its biggest year, reduces scientific emphasis

Liberal arts colleges are faced today with the greatest registration in American history. More undergraduates than ever before are thinking of a career in medicine; but the courses they pursue have undergone a subtle revision. Some educators believe that the end-result of these factors—the physician of tomorrow—may well be a changed product.

The trend in premedical education, up to the last decade, was to give a four-year liberal arts course with heavy emphasis on biology, chemistry, and the physical sciences. This was supposed to insure a steady crop of scientifically minded applicants for admission to medical colleges.

But the system did not always produce the type of applicant needed. The typical applicant for medical school admission possessed the needed scientific background but often lacked the necessary cultural and social background.

The rounding-out of such a student obviously could not be accomplished during his medical training. So the fact that it had to be done at the premedical level was eventually recognized.

The more progressive colleges then began to insist on a broadened curriculum for premedical students. As the plan became more widely understood, its philosophy was adopted by other colleges. Today it is generally accepted.

Dean Willard C. Rappleye of Columbia University's College of Physicians and Surgeons sums up the premedical trend in these words:

"Generally speaking, we can look for less emphasis on science subjects. This trend will reach its peak in the near future. It promises not mere medical technicians but well-rounded human beings. They are bound to be better physicians."

In his recent annual report to the

▶ Benjamin Fine, author of this article and Pulitzer Prize-winner, is education editor of the New York Times. Books he has written include "A Giant of the Press" and "Democratic Education."

president of Columbia University, Dean Rappleye pointed out that "for years the College of Physicians and Surgeons has placed emphasis upon those who are the most likely to succeed in medicine, rather than upon those who present the highest number of course credits or who have limited their preparation to the premedical sciences."

This standard for admission, educators admit, is not satisfied by a curriculum crammed with science subjects and tinged only incidentally with the humanities.

Prior to the war, most medical schools required a minimum of three years' premedical training for admission. Ninety-eight per cent of all applicants could satisfy that requirement, and more than three-fourths of them had baccalaureate degrees.

With the outbreak of hostilities, all educational processes were speeded. The required premedical training period was lowered by the Navy to three years, by the Army to two years. Now that the urgency of the war period has passed, however, the tendency is to revert to the pre-war three- or four-year standard, with no discernible movement to increase it beyond that point. It is significant that one major university is considering the adoption of a five-year premedical program, with a condensed three-year medical training plan leading to an M.D. degree. Here again, it is felt, a broader program in the humanities would result in a better qualified medical student, and ultimately in a superior practicing physician.

Says one medical school dean: "To prepare the student for the broadest aspects of medicine and for his responsibilities as a citizen of his community, he is advised to take premedical courses in psychology, sociology, and government. This is prompted by the increasing importance of psychosomatic medicine, preventive medicine, and public health in the modern medical curriculum."

More applications for admission to college for premedical training were filed in 1946 than in any previous year. This great upswing is a result chiefly of the greatest federal education subsidy of all time—the G.I. Bill of Rights. By paying all tuition fees and by adding a monthly allowance for living expenses, the Government is proving itself the financial patron of many a budding physician. Increases in tuition fees by as much as $15 a semester hour make this aid all the more timely.

The current crop of students ranges, according to college educators, from "very good" to "the best we've ever had." It is expected that huge premedical enrollments will continue for the next four or five years.

From 1935 to 1941, about 12,000 students applied each year for admission to medical schools. Six thousand were accepted each year, on the average. For 1947 it is estimated that 15,000 students will apply, but that again only 6,000 will be admitted. This ratio can result only in

an uplift in quality.

The great numbers of students seeking medical training will probably not bring any marked increase in the size or number of medical schools in this country. Last year these schools graduated 5,800 physicians. During the same year 2,600 practicing doctors died. The supply, therefore, seems ample to fill the gaps and still to provide for the increase in population.

It is dangerous to assume that the existing set-up in any educational field is serving its purpose and that there is no need to make drastic changes. However, the premedical training program in the United States would seem to justify this assumption. The opinion of medical educators in this instance is startlingly unanimous. A statement by Doctor Rappleye strikes the universal note. He says:

"Colleges throughout the nation have uniformly high educational standards. Their teaching techniques are good in the humanities and in the sciences. They take the raw material and shape it well enough for the medical colleges to turn out the finished product. What more can be expected of premedical education?" —BENJAMIN FINE, PH.D.

"HAVE YOU TRIED SLEEPING ON YOUR FACE?"

EYES, INC.

Air transportation is important factor in success achieved by Eye-Bank for Sight Restoration

America's only eye bank, two years old next month, has outstripped even the ideas of the ophthalmologists who founded it. They planned a central agency to collect, preserve, and redistribute eyes for use in corneal grafting. Now more than 200 physicians and 100 hospitals throughout the country participate in the program, and the bank also conducts several research projects.

Financed by voluntary contributions, the Eye-Bank for Sight Restoration is a private, non-profit corporation. Prominent physicians and laymen compose its board of directors and its advisory council.

Facilities of the Ayer Laboratory for Corneal Research at the Manhattan Eye, Ear, and Throat Hospital in New York City have been made available to the bank. There, eyes removed from donors all over America are received, examined, given a twenty-four hour culture test, and then rushed to physicians in participating hospitals. Two-way air transportation, a vital factor in the program, is furnished free by all major airlines. Cooperating in the transportation job is the American Red Cross.

Eye-bank technicians and a number of ophthalmologists to whom the bank has awarded fellowships carry on continuous research at the laboratory. Some of their goals are extension of the period of eye-preservation, reduction of bacteriological infection, improvement of operating techniques. Physicians who have completed post-graduate studies under eye-bank auspices are now practicing in seven states.

Biggest problem the bank has had is finding donors. But publicity is getting results. Persons in all walks of life have "willed" their eyes to the bank and in some states the autopsy law has been revised to permit the next-of-kin to authorize removal of a relative's eyes after death.

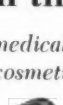
Publicity has also brought thousands of inquiries from blind and near-blind persons. Eye-bank policy is to refer afflicted persons to ophthalmologists who participate in the program.

Last year the bank established its first branch in Chicago. So far as is known, the agency is still the only organization of its kind in the world.

—RODMAN CLEMENT

Don't Pooh-Pooh the Cosmetic Case!

Women need medical attention for a number of cosmetic conditions



The manufacture of cosmetics has become a major industry; cosmetology, an important vocation. The millions who paint, powder, mascara, and manicure their way to beauty create both a responsibility and an opportunity for the medical profession.

Not long ago most physicians thought of cosmetics only in terms of their shortcomings. Articles in medical journals dealt primarily with their ill effects. Within the past decade, however, we have become more tolerant. We have learned that cosmetics often increase a patient's feeling of well-being by adding that extra something to appearance.

The efforts of the cosmetic industry are responsible indirectly for a number of visitors to our consulting rooms. Soap makers, face-cream manufacturers, hair-tonic purveyors, and the like have spent millions telling people about the dollar value of a clear skin, a non-scaly pate, an abundance of hair. No wonder our patients have become complexion- and scalp-conscious.

A cardiac may quite likely ask you how she can shrink the pores in her nose; a diabetic, whether rouge causes pimples. Stop a moment and recall how often patients have interrupted you with these and similar queries.

Reacting to the impression that medical men have no interest in such apparently trivial physiologic problems as acne, scaly scalp, baldness, wrinkles, and dry skin, beauty shop operators have encroached steadily on this field. Too often they even undertake the care of the ill. Their weight-reducing departments, for example, are now doing a big business—in both senses of the term.

This poaching on the territory of the physician makes it advisable for him to change his attitude toward

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▶ Herman Goodman, M.D., author of this article, is a practicing dermatologist. He is the author of "Treatment of Common Skin Diseases," "Cosmetic Dermatology," and a number of other books and papers on the phase of his specialty discussed here.

complaints he has been accustomed to consider lightly. Let's give the adolescent girl, heartbroken over pimples and blackheads, more than a cursory glance and an intimation that a change of diet will clear up her condition. If we don't, she will turn inevitably to Madame Therese's Beauty Shoppe.

Unfortunately, Madame T. may not recognize symptoms of bromine acne or the skin manifestation of a severe body ailment—any more than Giuseppe, the barber, is likely to distinguish scalp psoriasis or a symptom of diabetes from simple dandruff. What is ordinary loss of hair to a coiffure artist may be a sign of syphilis to an M.D.

My experience leads me to believe that physicians who merely damn the cosmetic industry are not giving themselves or the damned a proper break. Informed manufacturers recognize the danger of beauticians trying to be doctors. Many beauticians, for their part, would gladly refer patrons with skin and scalp disorders to physicians—but they're afraid to!

I have received letters from beauticians throughout the country requesting the names of open-minded physicians to whom they could go for advice and to whom they could send patrons requiring medical attention. Many of them cite experiences such as this: A woman suffers ill-effects from some cosmetic procedure and is advised to see her physician. The doctor explodes: "These so-called beauty experts are a public menace. You ought to sue the one who did this to you. Don't ever go near her shop again!"

Of course, the beauty operator may be at fault. But unless she gets less vitriolic treatment from the physician, she'll try, by herself, to patch up the damage she does. She may even decide, in self protection, not to send him patients whose troubles are no fault of hers at all. That may be hard on her, on the victim, and on you.

In suggesting more attention to cosmetic problems, I do not imply that room should be made for a permanent-wave apparatus in every doctor's office. But I do say that physicians should attend to such abnormalities as an oversupply of hair, diseased scalps, skin eruptions, and obesity.

When you come right down to it, why shouldn't the medical man broaden his sphere and qualify as a counselor in cosmetic dermatology? He is already prepared to treat burns from permanent-wave machines, nail-groove infections from improper manicuring, dermatitis from chemicals used in cold-wave permanents, the ill-effects of hair dyeing, and such; it doesn't take too long to become conversant with the cosmetic requirements of normal, healthy skin.

Conferences with leaders in the cosmetic industry have opened my eyes to the following:

Beauty shop operators want to go more than half way in fostering cooperation between themselves

and physicians. Manufacturers, seeking to test products, have confidence in and solicit the judgment of M.D.'s familiar with cosmetics and their potential effects. Insurance companies want specially qualified physicians to examine and treat those who make claims for injuries at the hands of beauty operators. Thousands of patients need medical advice about cosmetics and beauty treatments. A few states require schools for beauticians to include physicians on their staffs; more will soon follow suit.

The beauty industry has much to contribute to the physician. The chemists and consultants for this huge business have uncovered many things of importance to the medical care of the sick. Made available through commercial channels are new soaps and soap substitutes for the diseased skin, new detergents for scalp care, new ointment bases, new combinations of recently synthesized chemicals.

The official pharmaceutical texts are required to forgo listing many of these important contributions because of patent or other limitations. But the physician would do well to become acquainted with them none the less. —HERMAN GOODMAN, M.D.

What's Ahead for Blue Cross

Enrollment ceiling seen near unless internal problems are solved

After a dozen years of rapid growth, Blue Cross is now approaching the point at which many a booming new enterprise stumbles. That is the point when initial impetus begins to slacken and previously outdistanced problems start to catch up.

Blue Cross is here to stay. It has performed immeasurable service to the American people. But it has flourished partly because no standards existed with which to compare it. Now, weaknesses in organization and philosophy are becoming evident. It will take ingenuity and adaptability to keep the movement in the big time.

Outwardly, Blue Cross has never enjoyed greater prosperity or brighter prospects than it does today. In many ways, 1946 brought the greatest progress since the plan's start. By the end of 1947 Blue Cross should cover one of every five men, women, and children in the U.S. In some places it has enrolled nearly 75 per cent of the population, including indigents, the aged, and all other classifications. The history of health economics offers no comparison with this movement, which many people so heartily disparaged in its beginnings and so loftily patronized a few years ago.

Certain well-known characteristics distinguish Blue Cross from conventional insurance. It is frequently described as a method of "paying in advance" for hospital care. Actually, it also spreads the expense by dividing more or less evenly among its members the total anticipated cost of hospitalization. It is non-profit; it is fostered by the hospitals; it meets standards established by the American Hospital Association.

Most important, however, are the devotion of Blue Cross to the service principle and the operation of Blue Cross at low overhead. The service principle means that, within certain broad limits, Blue Cross patients have nothing to pay for hospitalization except their premiums. In contrast is insurance that pays a cash indemnity, often insufficient to cover the total bill,

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► Gordon Davis, author of this article, served formerly as public relations director of Blue Cross in Michigan. He now handles public relations for the Cleveland Hospital Service Association, and is also affiliated with a commercial insurance company.

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after hospitalization has occurred. The service idea frees Blue Cross members of a great economic uncertainty and has correspondingly great popular appeal.

To the lasting credit of Blue Cross has been its drive to broaden its service to members. In its early history, only certain types of illness were covered. Most of the eighty-odd Blue Cross plans now cover all types of hospital cases, including obstetrical. The leading plans are now close to their announced intention of being able to say, "We pay your hospital bill, period"—the "period" denoting that, for all practical purposes, there are no exceptions to complete hospital service.

There is a considerable gulf, however, between the coverage of the best Blue Cross plans and that of the poorest. Some plans have barely approximated the idea of service protection. Often there are ceilings on the value of "extras" available to members; the days of care permissible in certain cases are especially limited; there are even ceilings on the room rate allowable.

For the weaker plans to broaden their benefits is difficult—yet imperative. Although, this is primarily a problem for Blue Cross and hospital leaders, they cannot succeed fully without the cooperation of medical men. Few physicians appreciate the extent to which the fate of Blue Cross is in their hands. The individual doctor is in effect a claim agent for Blue Cross, since Blue Cross has never set up claims departments to determine the validity of subscribers' applications for care.

The mere fact that a doctor approves a subscriber for admission to a hospital is accepted as sufficient evidence that the claim is justified. If the doctor prescribes extra or special service, Blue Cross considers this *prima facie* evidence of need. A remarkable tribute to the integrity of the medical profession arises from the complete success of this broad policy.

As Blue Cross broadens the base of its service, however, the doctor must guard increasingly against an impression that the economic lid is off. The physician's skilled judgment of the patient's true need will be the sole safeguard against misuse of Blue Cross benefits.

In the Blue Cross program to achieve complete hospital service, another problem intimately affects doctors: Many plans have tried to cover every essential service normally appearing on the hospital bill. Among these items are radiological and pathological services.

It is not claimed that these are hospital services. However, they usually appear on the hospital bill. Many medical men insist that Blue Cross, a hospital-fostered program, cannot pay for these services. They are medical, rather than hospital, in origin, they argue.

Settlement of this controversy should be the serious concern of both the medical profession and the hospitals. Blue Cross has no place in the argument about professional economic jurisdictions; but it suffers progressively as settlement is delayed.

Perhaps the greatest barrier to full attainment of the Blue Cross service ideal is that built around the idea of "participating" or "member" hospitals. There are about

eighty-six Blue Cross plans in the United States and Canada. Some are state-wide; others confine their operation to metropolitan areas or to a few counties. No two overlap or compete.

As far as the individual Blue Cross plan is concerned, service benefits are assured only in that plan's member hospitals. Subscribers hospitalized in non-member hospitals receive what amounts to cash indemnification toward the hospital bill. What they get is often much less than the value of the services to which they would be entitled in member hospitals.

Blue Cross has tried to circumvent this difficulty by what is called a reciprocity program. But it fails where there is marked variation between the benefits of any two Blue Cross plans. It also fails when the subscriber is admitted to a hospital that does not participate in any plan. Moreover, not all the plans have entered into reciprocity agreements. Some are openly opposed to the idea.

Reciprocal agreements are necessary largely because a number of plans pay their own member hospitals less than the hospitals' regular established rates. Many hospitals vigorously defend rate concessions to Blue Cross; others bitterly oppose them.

Increasingly, Blue Cross plans are solving this controversy by paying hospitals their regular public charges. It is a good guess that all will ultimately do so. Member hospitals will then no longer give financial concessions to Blue Cross. When payment of regular charges becomes general, there will be no need for a reciprocity program. The cash allowance paid to subscribers laid up in non-member hospitals will then be sufficient to pay for the services they receive there.

Undoubtedly Blue Cross and the hospitals will work out these problems. There is less reason for confidence, however, in their ability to solve the biggest problem of all, that of national cohesion.

Blue Cross spokesmen have for years seen the need of a uniform national contract. Such a contract would assure a firm having plants in several plan areas that all its employes would receive a fixed minimum of Blue Cross benefits. Today national employers sometimes have to deal with dozens of Blue Cross plans that offer varying benefits. Small wonder that the employer protests against disparities, that he is irked by the necessity for explaining these to employes transferred from one area to another, that he is dismayed at having to know the differences between benefits of dozens of Blue Cross plans.

Nevertheless, Blue Cross seems no nearer a uniform national contract today than it was five years ago. Too many plans cannot agree on it. The situation resembles that of the thirteen colonies before the Constitutional Convention, except that instead of thirteen entities there are more than eighty.

Blue Cross confronts a number of other important but less pressing needs. Among these are closer coordination with medical service plans, better methods for enrolling farmers and the self-employed, and higher sensitivity to what the subscribers want.

Blue Cross can and should ultimately enroll at least two of every

three Americans—a total of nearly 100 million people. If it does not meet its present problems squarely, however, enrollment probably will reach its peak somewhere between 30 and 40 million.

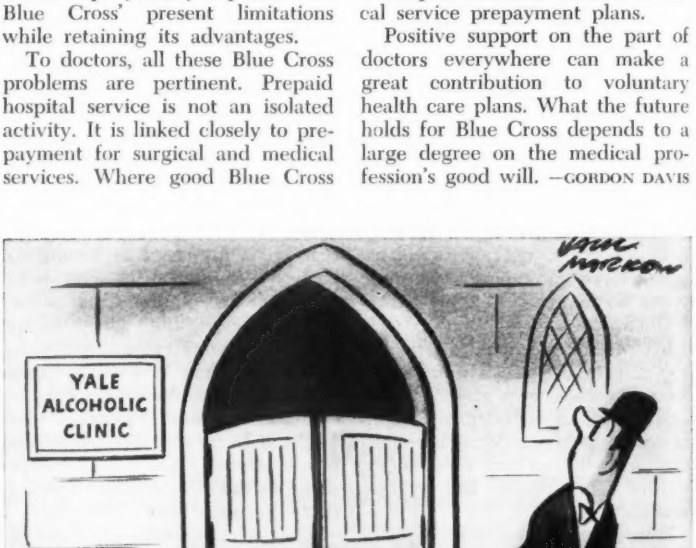
For a decade, Blue Cross has had no true rivals. Now competitors are appearing. Old insurance companies have in some cases produced hospitalization policies that actually compete with Blue Cross. In one instance, a group of former associates has organized a new insurance company. They hope to avoid Blue Cross' present limitations while retaining its advantages.

To doctors, all these Blue Cross problems are pertinent. Prepaid hospital service is not an isolated activity. It is linked closely to prepayment for surgical and medical services. Where good Blue Cross and medical service plans function in harmony and in close cooperation, the results of this team-work are phenomenal. It follows, then, that doctors have a stake in Blue Cross for two fundamental reasons:

First, the future freedom of the medical profession is involved in the success of voluntary sickness and hospitalization insurance.

Second, medical service plans fostered by the profession cannot flourish in the absence of good hospital service plans, and most Blue Cross problems also exist for medical service prepayment plans.

Positive support on the part of doctors everywhere can make a great contribution to voluntary health care plans. What the future holds for Blue Cross depends to a large degree on the medical profession's good will. —GORDON DAVIS



Bevan Assays Peacemaker's Role In British Health Dispute

Non-participating physicians agree to negotiate state medicine details

Health Minister Aneurin Bevan was still trying last month to implement Britain's National Health Service Act. He wanted to discuss operating plans with the British Medical Association. The association's members had voted not to negotiate with him; but so conciliatory was a letter Mr. Bevan wrote the BMA that members attending a special meeting voted to discuss application of the act. After negotiations with the Government are completed, the BMA will again poll its members on whether or not they will participate.

Said Mr. Bevan: "This issue for doctors today is not whether they will join a service, the final shape of which cannot yet be known. The issue is whether or not they will accept the chance to shape that service. I shall endeavor to meet any views of the profession which do not conflict with the principles of the act."

The Health Minister's placatory note was addressed to the presidents of the three royal colleges of medical science. They had seized the initiative in an attempt to break the deadlock between Mr. Bevan and the BMA, a deadlock that threatened to render the National Health Service Act unworkable.

Passed at Parliament's last session, Britain's law for socialized medicine was last month still devoid of the administrative details needed to make it work. While BMA members voted, Mr. Bevan spoke out on two main points of contention.

Under state medicine, he declared, all participating doctors should be put on a salaried basis. BMA physicians hold that it would be preferable for most of their income to come instead from a per capita fee, based on the number of patients treated. The Health Minister took cognizance of this view but said that "for administrative reasons" it was easier to have a small salary for each doctor. In some cases, he said, a guaranteed minimum would probably be necessary.

Medical men said that under the new law, Britain's Health Minister would be able to order doctors from one place to another. Not so, said Mr. Bevan. To keep too many physicians from concentrating in one area, he explained, doctors would have to check with a local medical committee before moving. He pointed out that physicians would constitute a majority on local committees and that the profession would control the distribution of doctors.

—MELVIN SCOTT

SOLON

Walter H. Judd, Republican member of the House of Representatives, from Minneapolis, owes his career as a physician-politician to the fact that while in high school he read a biography about Livingston —the man of "Doctor-Livingston-I-presume" fame. "By the time I laid the book down," he says in a twangy voice, "I had decided that the life of a doctor was the life for me.

"Livingston picked Africa to practice in. I found that the place with the most people and fewest doctors was China. So in 1925 I went there."

While in China, Doctor Judd spent a good deal of his time picking American scrap iron out of Chinese casualties of the Japanese expansion. In 1938, he decided to take a ship home to jog the American public into awareness of the Jap menace. "I knew we'd soon be picking that scrap iron out of Americans," he says.

Between 1938 and Pearl Harbor Sunday, the doctor spoke 1,400 times in 486 cities. Even when he finally settled down to medical practice in Minneapolis, he continued to act as unofficial goad to the community conscience.

One day a friend cornered him and asked why he did not run for Congress. Always a man with a low resistance to the call of duty, Doctor Judd yielded. That was in 1942. He has been in Congress ever since, trying to make his experience in the Orient useful in the tangled field of Asiatic policy.

WATCHDOG

A young Kansas City, Mo., surgeon, Brigadier Gen. Wallace H. Graham, has the most exclusive office address in the U.S. It is 1600 Pennsylvania Avenue, Washington—the White House.

General Graham has been President Truman's personal physician since August 1945. He is a veteran of Omaha Beach, the Battle of the Bulge, and other major campaigns (in which he earned the Purple Heart and Bronze Star) and was in Stuttgart when he learned of his appointment. A month later he was ensconced in an office suite on the ground floor of the White House, a physician with only three regular patients: the President, Mrs. Truman, and daughter Margaret. "The President is a good patient," he says. "As far as matters of health are concerned, he does what I tell him."

General Graham knew Mr. Truman only slightly before his appointment; but his father, Dr. James W., was an old friend. The younger Graham—he's 36—is a graduate of the University of Missouri, where he was on the boxing and track teams, and of Creighton University Medical School. He had had two years of private practice with his father before joining the Army in 1941.

The country's "most disemployed" physician, as one newsman dubbed him, teaches surgery at George Washington University Medical School, practices it at the Walter Reed Hospital, and works on a cancer research project.

NIMROD

One of this country's best-known big-game hunters is Frederick W. Rinkenberger, a sinewy Los Angeles surgeon, who became interested in the sport about ten years ago. Since then, he says, he has bagged every type of American big game ("from a coyote to a nine-foot grizzly") except the Stone sheep and the Kodiak bear. Doctor Rinkenberger would

probably have had the Kodiak bear, whose habitat is the Alaska Peninsula, last fall, but his boat was delayed by a heavy storm in Cook's Inlet and he reached the hunting grounds after the bear had left.

Though his interest in big game dates back only to the middle 1930's, Doctor Rinkenberger has hunted all his life. Interested in rifles and bullets since boyhood, he is now a recognized expert on hunting "tools." Last year, in an article in the American Rifleman, he wrote, "There is more nonsense, prejudice, and complete ignorance expressed about guns than about any other subject I know." His pet rifle is a .300 Magnum equipped with a telescopic sight, a favorite among Marine sharpshooters.

In assessing the relative effectiveness of various bullets, Doctor Rinkenberger finds his experience as a surgeon useful. "I have done a good deal of research in the effects of bullets on tissue," he says. "I did this in World War I, when I was chief surgeon at a base hospital. I continued when I became chief surgeon at Central Emergency in San Francisco, where we saw a lot of gunshot wounds." He checks the effect of bullets on every animal he kills.

Several years ago, the Corelokt and Silvertip bullets were put on the market. They are especially made for big game hunting and Doctor Rinkenberger helped design them. In such ways, the doctor's studies have had practical application.

He does most of his hunting during annual vacations. In the past, his trips have taken him to British Columbia and the Yukon. Even so far from home, he always hunts "solo," except for guides. "They won't let you go after big game in those places without a guide," he says a little resentfully.

"Killing big game is not dangerous for an expert who is adequately armed," he says. "The danger comes with inexperienced hunters inadequately armed."

The doctor's score for his last Yukon trip is proof enough of his ability with a rifle. He dropped two grizzlies, each with a single shot, at about 75 yards. Three well-placed bullets brought down three caribou at ranges up to 200 yards; but he needed an extra shot for a moose at 400 yards.

His confidence in his aim is sometimes amazing. He once killed a Dall sheep at 175 yards. Later he commented: "I took two shots, one in the shoulder, the second through the head, in order not to take chances."

A shot that Sergeant York would envy was Doctor Rinkenberger's third try at another running sheep. The bullet broke the animal's leg at a range estimated by his guide at between 700 and 800 yards.

The doctor's sportsmanship matches his eyesight. He damns the hunter who will let a wounded animal suffer needlessly, rather than hike half a mile over tough terrain to kill it. "The animal that furnishes a man's sport deserves consideration, too," he says.

With three moose, four grizzlies, three caribou, and a variety of other animals to his credit, Doctor Rinkenberger does not intend to be cheated of his Stone sheep and Kodiak bear. "The sheep I will get this coming August," he predicts darkly; "the bear, next spring."

When You're Called on to Testify

What you should know about courtroom testimony, and how to present it

The mere idea of testifying in court is enough to give some doctors the willies. Other men find courtroom testimony a source of increasing professional prestige, not to mention income. It all depends on whether or not you have the know-how.

While there's no substitute for experience, you can learn what to expect and how to meet it by reviewing the tips offered by veteran witnesses. MEDICAL ECONOMICS has distilled the experiences of half-a-dozen successful medical experts, and presents their suggestions in three down-to-earth articles. If you check over these courtroom cues before your next legal outing, it's likely you'll find that witness chairs *can* be comfortable.

TYPES OF MEDICAL TESTIMONY

The doctor may testify in any of three capacities:

¶ He may be an ordinary witness to facts not requiring medical knowledge.

¶ He may testify to medical facts.

¶ He may qualify as an expert.

The first situation is simple. You, like any other citizen, may be called to testify to what you have observed. If you saw a collision between two trucks and one of the drivers jotted down your name and address, you may have to go to court and tell the jury what you saw. Your status then is that of any ordinary witness.

As a doctor, you may be called on to testify to (a) facts or (b) opinions. The family doctor, the interne, or the physician who gave first aid is often required to give medical fact testimony. As a fact witness, you testify to what you saw and when you saw it. You may be asked how much your fee was, who paid it, how long the laceration was, how many sutures you inserted. All these are factual questions calling for factual answers. You can be compelled to give such testimony by subpoena and are not legally entitled to anything above the nominal subpoena fee. On this basis, you cannot, however, be asked an opinion. Suppose, for instance, you have treated a patient and did not feel that she has any

▶ This article is the first of three that will deal with preparing for court appearances, how to testify, cross-examination, witness fees, and related topics. The series has been prepared by Leslie S. Kohn, LL.B., former managing editor of the New Jersey Law Journal.

real legal claim. You do not wish to go to court. Nevertheless, a process server has wormed his way into your office and left on your desk a fifty-cent piece and a sheet of paper reading: "You are hereby commanded to lay aside all other business and be and appear in your proper person before . . ."

You have to go to court and, if asked, tell the jury when you saw the patient, what you found, what you did and how much you charged. If the attorney describes the accident and asks, "What relationship existed between the accident and the symptoms?" he is calling for an opinion. And he is not entitled to that for his fifty cents. You can say, "That's a matter of opinion, and I am here on a subpoena as a fact witness, not an expert." Usually the attorney at that point will agree to pay you for your time and accept you as a medical expert.

Most medical witnesses come in as experts from the beginning. An expert does not have to be a specialist. Any regular medical license indicates that in the opinion of the state, the doctor is qualified to practice medicine, surgery and obstetrics in all their branches. An expert is not of necessity a specialist; he is a physician giving medical opinion rather than medical facts.

Medical fact testimony differs from expert medical testimony in four particulars:

¶ The expert can be subpoenaed but not to give an opinion. He must give his opinion voluntarily.

¶ The expert may be asked to qualify in point of his specific experience and skill.

¶ The expert may give opinions, prognoses, and evaluations; the medical fact witness is limited to simple objective facts.

¶ The expert is entitled to appropriate compensation for his time and special service.

PREPARATION OF RECORDS

In court, your office record may be seized and examined by the judge, by the attorneys, and even by the jury. Moral: Have a record so well prepared that you would not be ashamed to have the whole American College of Surgeons inspect it.

Sloppy records often humiliate medical witnesses. Moreover, since the record is the basis of your testimony, you can't give good testimony unless you have an adequate record to rely on. A highly successful medical witness whose records have always been something to be proud of explains it thus: He keeps on his desk a thirteen-point check

'That You Will'

A department-store salesgirl came to my office for treatment of a second-degree burn on her leg. After I had taken care of it, I said, "Mary, I want you to stay off that leg for a while."

"That'll be easy, doctor," she answered in all innocence. "I'm getting married Saturday, so I'll be off my feet for a whole week."

—M.D., OHIO

list. Whenever he sees a patient who was involved in an accident, or whose case might for other reasons reach a judge's docket, he checks and double-checks his office file against these thirteen points. Here is his list:

1. Dates are accurately entered. Every visit is dated. So is every phone call and conference.

2. The source of the patient is written down. If the lawyer sent the patient to the office, that fact is entered.

3. The "how," "when," and "where" of the accident are completely explained.

4. Hospitalization data are obtained and entered in the history. Specifically, the doctor includes (a) name of the hospital; (b) hour and date of admission and discharge; (c) whether sutures were inserted, and how many; (d) whether patient was conscious, semiconscious, unconscious, drunk, sober, walking or not, when admitted. The doctor includes this information in his record even though he can testify only to those facts of which he has personal knowledge.

5. The patient's own words are used in writing the history and complaints. For instance, if the patient says that last year she had an "operation on the womb" or an attack of "Bright's Disease," it is written that way, and not as "hysterectomy" or "nephritis." When the doctor testifies that an illiterate plaintiff complained of "insomnia and tinnitus," even the jury laughs.

6. In all cases (no matter where the lesion) five basic facts are recorded among the findings. These are height, weight, bloodpressure, pulse, and the size and place of scars. Remember to measure all scars, preferably in inches.

7. Findings of the examining physician are carefully separated from information acquired from other sources. If the word "anxiety" appears in the examination, for instance, it must be so placed that it is apparent whether the doctor *found* that the patient showed anxiety or whether the patient *said* he suffered from anxiety.

8. Any items not in the doctor's handwriting are initialed by him. If the nurse took height and weight, the physician cannot testify that on that date the patient weighed so much; but if he can honestly say that the weight was taken at his request and under his supervision, he may testify about it. The doctor's initials there serve to corroborate his statement.

9. The findings of a radiologist are entered in the record after the doctor has reviewed the films and confirmed the report. The doctor is then able to testify about his own interpretation of the X-ray.

10. The originals of all laboratory reports are kept in the file. The date on which such procedures are ordered is indicated in the doctor's handwriting, as well as the date on which the report was received and an abstract of the findings.

11. The financial data are either copied on the clinical record or, if separately kept, removed and attached to the record when it is brought to court. This includes bills sent and fees received, with dates, and a note of who actually paid the fees.

12. A carbon copy is retained for every record, report, and letter sent out. There are no exceptions to this

rule. If a report is filled out on a blank form, the questions as well as the answers are entered on the carbon copy. For example, the form might have a printed question, "Is the claimant now ready to return to work?" and you might type in the answer "no." Your carbon copy would then show "no" all by itself. Six months later, when you picked up the record, you'd have to rack your brains to figure out what you had said "no" to. The solution: Have your secretary type the questions on the carbon copy.

13. At least once on the record, and more often if the patient is seen for a long period, a note is entered as to extent of disability. The disability should be judged by six indices. They are: (a) How much does it impair earning capacity? (b) How much does it impair vocational efficiency? (c) How much does it impair employability, that is, the patient's chance of getting a new job with this defect? (d) What is the functional (physiologic) loss? (e) Is there any cosmetic defect? (f) Do the emotional effects of the accident cause any disability?

This thirteen-point check-list may look formidable, but a record that meets these requirements is one the doctor need never be ashamed to expose in a courtroom.

PRE-TRIAL CONFERENCE

The inexperienced medical witness should ask for a pre-trial conference with the attorney. Lawyers are advocates and therefore strive to present the case only in a favorable light. This may mislead the doctor. The attorney will assure you that the patient was never sick a day in his life until he was involved in the accident. Be skeptical about this and ask questions. Ask the attorney how he will qualify you. Prepare a list of your qualifications in advance. If you don't, you'll forget half of them in the stress of testifying. Before you go to court, list your interneship, residencies, graduate courses, articles written, society memberships, and staff connections. Find out whether you will be asked to qualify on a blanket basis, *i.e.*, by answering the query, "What are your qualifications?" or whether the attorney will bring out your qualifications by a series of questions like: "Where did you interne?" or "With what hospitals are you now connected?"

The pre-trial conference is also the time and place for framing hypothetical questions. Plan to include all the medical facts, not merely the helpful ones. Review the question phrase by phrase. And, finally, don't be afraid to admit on cross-examination that such a conference took place. It's perfectly proper.

PREPARATION FOR TRIAL

Preparation for the trial is time well spent. Even a thoroughly experienced witness reviews the anatomy of the organs involved. It is

Handitip

Telephone Light

Ever been blinded by a bright light when you've gotten up to answer a phone call in the middle of the night? A luminous dial slipped over the regular one on your telephone will eliminate having to turn on a lamp.

well also to become familiar with recent literature on the subject. The general literature includes five well-known books. They are packed with helpful hints on medico-legal problems.*

Let the prospective witness consider, too, the points on which he is likely to be cross-examined. If you are to testify that an accident caused certain symptoms, consider honestly whether any pre-existent disease might not also have been a factor. How will you answer a question as to possible malingering? If the doctor is testifying for the defense, he will probably say either that the accident did not cause the symptoms or that the disability is trivial and temporary. Consider how this will be attacked. How will you answer the inevitable query, "The patient was well before the accident, and is sick now; how do you explain that?" or "If the disability is temporary, how is it that three years after the accident he is still unable to work?" Finally, remember that you will be asked how many such cases you have seen before. Be prepared with an answer. —LESLIE S. KOHN, LL.B.

[To be continued next month.]

*Trauma and Disease by Leo Brahdy and Samuel Kahn, Lea and Febiger, Philadelphia; Fraud in Medico-Legal Practice by Sir John Collie, Edward Arnold Company, London; Accidents, Neuroses and Compensation by J. H. Huddleson, William and Wilkins, Baltimore; Accidental Injuries by Henry H. Kessler, Lea and Febiger, Philadelphia; and Medico-Legal Injuries by Archibald McKendrick, Edward Arnold Company, London.

New Taft Health Measure May Get Senate Approval This Year

Ohio Senator incorporates M.D.s' views in revised medical care bill

Washington legislators turned a calculating eye last month toward a revamped National Health Bill that Senator Robert A. Taft (R., Ohio) had pushed into the Senate spotlight. Hearings on the bill were tentatively booked for "sometime in March," when the upper house was "hoping" to wind up its labor probe.

Meanwhile, medicine's representatives kept a close watch on the bill's progress. More than any recent health legislation, it embodied the views of the profession on how medical care could best be extended.

The Republican majority had charted its legislative course carefully. Labor and taxes were first on the list. Once they were out of the way, the Senate Committee on Labor and Public Welfare expected to turn to health legislation. Last year that committee was under the whip of Senator James E. Murray (D., Mont.), whose best efforts to pry out of committee his own bill for compulsory health insurance came to naught. This time the chairman is Senator Taft himself. On-the-scene observers predict that he'll get his new National Health Bill onto the Senate floor in jig time.

The new bill embodies many fundamentals of the 1946 version, which ran under the colors of Taft, Smith, and Ball as S. 2143. It would gather scattered Federal health groups into a new, independent National Health Agency under the reins of a physician. Its prime emphasis is on helping low-income groups to meet medical bills. Its price-tag: $1 billion in Federal grants-in-aid over a 5-year period. Its prime movers: the states themselves, which would be free to work out their own medical-aid programs.

Last month Senator Taft outlined for MEDICAL ECONOMICS the prospects of his new measure. Said the Ohio legislator: "So many changes in the bill have been suggested that we haven't had time to work all of them over. I don't think we can start hearings until we get through with the labor hearings."

When he introduced S. 2143 last year, Senator Taft called the bill "not perfect," and invited comment from medical men. The result was one of the greatest outpourings of constructive criticism that physicians have ever directed toward a Washington lawmaker. The Senator met with groups from the AMA, from state medical societies, from local academies of medicine, even with individual physicians.

[PLEASE TURN TO PAGE 70]

Handitip

Softer and Safer

You can save bruises and preserve dignity by anchoring your slippery rugs to a new, washable, sponge-rubber cushion that does not mar the floor. Cut to fit the rug, this under-cushion clings even to waxed surfaces

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Senator Taft termed these conferences "most productive." But he added, "I don't think physicians quite understand the Governmental end of the job. They favor a Federal grants-in-aid program, but they want the Federal Government to write the law just the way *they* want it written. Now, what we're trying to do is to promote health through Federal assistance without Federal regimentation. Many of the physicians' specific ideas should be brought into the individual state set-ups, rather than into the national law."

What were the chances for enacting the new bill? Said Senator Taft: "It's hard to say at this stage, but I think there's some chance. I don't think it will get through both houses this year, but I think it will get through the Senate." As of last month, no companion bill to the Taft-Smith-Ball measure was yet in sight in the House of Representatives.

Medical men centered their scrutiny of the new bill around its three major changes from last year's version. These changes would

¶ Put new emphasis on a medical survey to be conducted by each state to determine its true medical needs. Patterned after the Hill-Burton hospital surveys, the studies would draw $3 million in Federal funds, and would require matching funds from each state.

¶ Take administration of the medical phases of the bill out of the hands of the Public Health Service. Last year's version called for the PHS Surgeon General to direct medical services for low-income groups. This year's bill calls for an Office of Medical and Hospital Care Services whose M.D.-director would rank on a par with the Surgeon General. Both would be under the M.D.-administrator who would boss the entire National Health Agency.

¶ Give equal recognition to dentists by setting up an Office of Dental Services. Under the agency's top administrator, it would be independent of the medical branch.

The specific goal of the National Health Act of 1947 is to provide Federal assistance for improving medical care, but to have the program administered by the states. Says Senator H. Alexander Smith (R., N.J.), one of the sponsors: "We want to get away from the idea that some bureaucrat here in Washington can say to each state, 'Follow my instructions or you don't get any money.' "

Each state would have five years to develop a program for providing medical service to those unable to pay for it. Each state would have to match Federal funds on a $1-for-$1 basis. For their low-income groups, the states would be encouraged to pay premiums to voluntary health insurance plans.

Practicing physicians have thrown their weight against domination of the proposed National Health

Agency by PHS personnel. This move reflects the profession's distrust of administrators who lack experience in private practice and who are sometimes inclined toward compulsory health insurance. As a result, the new bill calls for several separate subdivisions under the top administrator. Besides the Public Health Service, the Office of Medical and Hospital Care Services, and the Office of Dental Care Services, there would be the Children's Bureau, the Food and Drug Administration, and an Office of Health and Medical Research.

The 1947 Taft Bill would be administered by state health agencies. Many medical men would prefer to have it otherwise; they have suggested advisory councils with veto powers in each state. But the sponsors feel that state health agencies must be built up and that forty-eight groups with veto power would hinder the program more than help it.

How does the National Health Bill of 1947 compare with the Wagner-Murray-Dingell Bill? Says one analyst: "The W-M-D Bill is a shotgun method of curing the country's medical ills. By taxing everyone for medical care, it hopes somehow to correct present inadequacies. The Taft Bill provides help in meeting medical costs for the only group that finds them really burdensome: our low-income families."

Says another: "The sponsors do not believe there is justification for compelling the entire population to enter a compulsory sickness insurance scheme because *some* people in *some* communities need aid in paying for medical care. They believe it is sounder to aid the few rather than to coerce the many."

Other observers are disturbed by the apparent incompatability of two bills that bear Senator Taft's name: S. 140 and S. 545. The first sets up a Department of Health, Education, and Security. It lumps medical services with welfare under a cabinet-rank, non-medical administrator. The other sets up an independent National Health Agency, under a doctor of medicine.

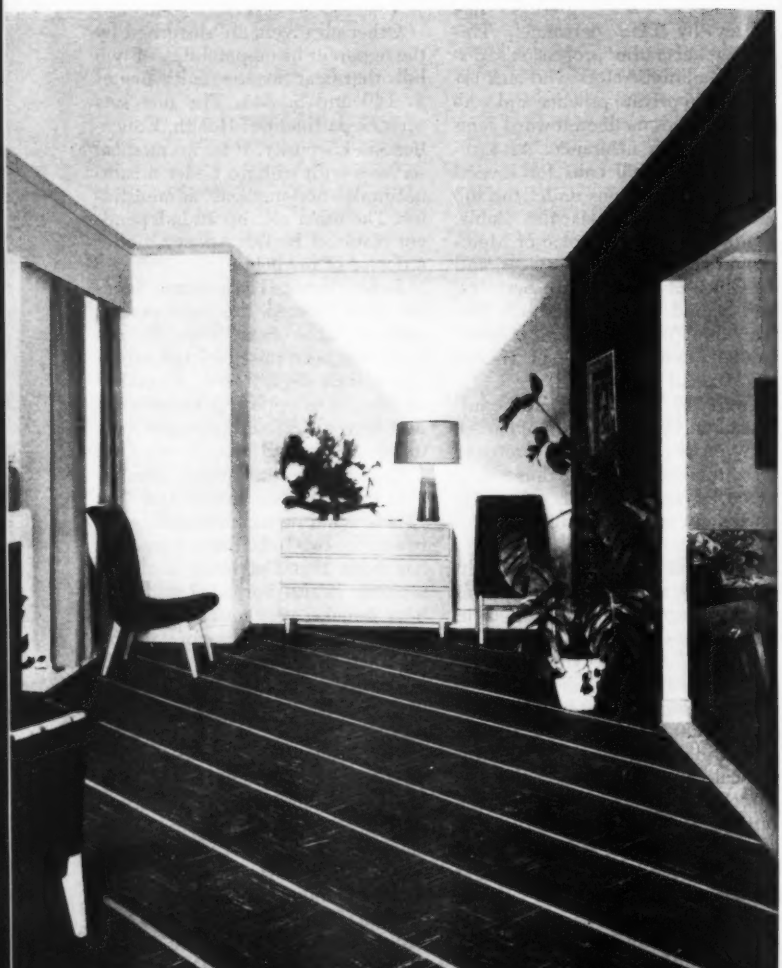
In floor debate last summer, Senator Taft favored the independent agency. Since then, a public demand has been raised for the tripartite welfare department. A number of physicians oppose it on grounds that it would subordinate medicine to lay administrators.

Queried on this point, Senator Taft told MEDICAL ECONOMICS that "There is a little incompatability between the two bills. But my position has been that I'm interested in a separate health bureau. I don't believe it makes very much real difference whether that bureau is directly under the President, who will never pay much attention to it anyway, or whether it is under a cabinet officer.

"Physicians are a little afraid that the cabinet officer will be a welfare man. But I think an M.D. undersecretary can protect the status of the health bureau. I don't want any intermediate fellow in between the Secretary and the head of the health bureau. But I don't see why the health agency shouldn't be just as independent inside a Department of Health, Education, and Security as outside it.

"It's my belief that, with minor modifications, both these bills could be worked out in the hearings."

—R. C. LEWIS



Your Office Floor Covering

Some tips on materials now available and what they cost to install

If you're among the goodly number of physicians who have an urge to refurbish their offices, you'll do well to start at the bottom. That means picking your floor covering first. Among the ten types described here, there's probably at least one that suits your taste, your need, and your pocketbook.

Wood: Many physicians have used floors of random-width planking, pegged flush at end joints, for decorative hallways and foyers. Such a floor makes a good rug base in larger rooms. Another possibility worth noting is wood block flooring, with the grain of each square at right angles to that of its neighbor. All hardwood flooring, of course, requires refinishing at regular intervals. Price-tags vary widely, starting at about $3.50 a square yard, installed.

Linoleum: The easily-cleaned quality of linoleum makes it a favorite in many offices. There are limitless possibilities for inlaid designs and colored markings. Cost

Is your reception room narrow? Then try diagonal stripes in your floor pattern (left) and notice the illusion of extra width they bring. To reduce the apparent size of a large, sparsely furnished room, use deep marginal borders. Linoleum is well adapted to inlaid patterns and designs (right).

Handitip

Ice-Breaker

Incoming patients gravitate instinctively toward your secretary's post. A nameplate on her desk will help a newcomer to start his conversation with her.

per square yard, installed, runs from about $2.50 to $3.50, depending on the thickness required. Good installation is essential; otherwise your flooring may develop curves that would look better elsewhere.

Rubber: For treatment areas, rubber tile is used by a number of doctors, at $4.50 to $5 a square yard, installed. Sheet rubber flooring will do much the same job for about $3.50 a square yard. You won't want to use either type where the flooring is exposed to oil or grease.

Cork: Though harder to clean than some floor coverings, cork carpeting softens the noise of footsteps, making it the choice of some for upstairs office rooms. It costs about $4 a square yard, installed. The same material can be had in tile form for about the same price.

Asphalt: Tile made of this material is one of the most popular of all floor-coverings in physicians' offices. It is low in cost (about $2 a square yard, installed), serviceable, and available in a variety of designs. Asphalt tile is vulnerable to grease and it dents under heavy pressure.

Plastic: The advantages of plastic flooring (grease-proof; resistant to fire, moisture, and acid) make it worth an M.D.'s scrutiny, although it is not yet in wide use. Flexachrome, Koroseal, Vinylite, and Lavernite are a few of the materials in the offing. Price is likely to be high for a while.

Leather: For special effects, you may want to consider the new leather-covered tiles finished with a protective plastic. The price is steep (more than $10 a square yard, installed), but for small areas the decorative impact may be worth it.

Terrazzo: White cement and marble chips are blended in this composition flooring. It is ground to a smooth polish after installation, is easily cleaned, and comes in many colors and patterns. The cost: $5 to $5.50 a square yard. Composition flooring is relatively cold and noisy, but it takes a lot of hard use.

Magnesite: Similar to terrazzo is the composition flooring made of magnesite. This material, however, can be applied in a greater variety of places, even over worn wood flooring. You can get it for $3 to $4 a square yard, installed. Composition flooring such as magnesite and terrazzo serves well in basements and in storage areas.

Fabrics: Atop your hard-surface floor covering you may want to use carpeting in reception and consultation areas. It helps absorb room noises and adds warmth. Many physicians prefer wall-to-wall broadloom. It is easily cleaned, will not scuff at the edges, and eliminates the need for fancy flooring. Oriental and hand-hooked rugs fit nicely into a room that is traditionally decorated. Fabric costs run the gamut, with chenille carpets up near the top at $24 a square yard. In several communities where prices have been checked, reasonably good grades of broadloom average about $7.50 a square yard. —JOHN G. SHEA

Pronunciation Quiz

By James F. Bender, Ph.D.

How do *you* pronounce these medical terms? Take your pick, then turn to page 156 for the answers. This is the fourth in a series of four quizzes. Capitalized syllables show primary accent; italicized syllables show secondary accent.

	A	B
1. ergotine	air guh TIGHN	ER guh teen
2. cochlea	KAHCH lee uh	KOHK lee uh
3. endemic	en DEM ik	EN deem ik
4. ductless	DUHK l's	DUHKT l's
5. adenoid	AD uh noid	AD noid
6. elephantiasis	*el* uh fan TIGH uh sis	el uh *fan* ti AS is
7. digestion	di JES ch'n	DIGH jes ch'n
8. conjunctiva	kuhn JUHNGK ti vuh	*kahn* juhng TIGH vuh
9. diapedesis	digh AP uh *dee* sis	digh uh puh DEE sis
10. clitoris	KLIGH tuh r's	kli TOH r's
11. epithelium	ep i THEE li 'm	***ep*** i thi LIGH 'm
12. coagulate	koh AJ yoo layt	koh AG yoo layt
13. fungicide	FUHN ji sighd	FUHN gi sighd
14. chemurgy	KEM er ji	CHEM er ji
15. buccal	BOO k'l	BUHK 'l
16. cheilosis	kigh LOH sis	CHAY loh sis
17. fenestra	fi NES truh	FEN uhs truh
18. cerebrum	SEHR uh br'm	su REE br'm
19. fetus	FEE t's	FET 's
20. allergy	uh LER ji	AL er ji
21. centrifugal	*sen* tri FYOO g'l	sen TRIF yoo g'l
22. alveolar	*al* vee OH lahr	al VEE uh ler
23. carotid	KAIR uh tid	kuh RAHT id
24. audiometer	aw di oh MEE ter	aw di AHM uh ter
25. capillaries	KAP i lair eez	kuh PIL er eez

James F. Bender, Ph.D., is director of the National Institute for Human Relations. He wrote the "NBC Handbook of Pronunciation" and "Salesmen's Errors of Grammar." System of notation used by permission of Sales Training Publishing Co., Roslyn Hts., N.Y., publishers of "Salesmen's Mispronunciations."

Getting V.A. Bills Paid Faster

Some do's and don'ts to help you cope with red tape

As more and more veterans make use of the Government's plan for home-town medical care, an increasing number of doctors contend that red tape in the Veterans Administration delays payment of bills. In certain areas, where the system involves a two-months' delay, the contention may be true; but in states where bills are generally paid within two or three weeks, slow payment is often the result of some error or oversight on the part of the physician in filling out official forms. In one state, 28 per cent of the bills received by the V.A. in one month contained errors.

Although the forms vary from state to state, in no area is the required paper work very complicated. Generally, it boils down to a three-step procedure:

¶ You must obtain V.A. authorization for the treatment of each eligible veteran, since the Government pays only for care that is authorized.

¶ You must submit a monthly bill in duplicate for your services.

¶ You must furnish a monthly report on your veteran-patients.

In most of the thirty-odd states where home-town care is available, local rules concerning plan procedure have been explained in state and county medical journals. Copies of such special instructions can generally be obtained from state society headquarters or from V.A. regional offices.

AUTHORIZATION

In applying for the all-important authorization, use the form approved for your locality. Remember that in its home-town care plan the V.A. pays only for the treatment of service-connected ailments or for conditions aggravating such ailments.

Ask the veteran for his discharge papers before filling out the application form. Copy his name, date of enlistment, date and kind of discharge, his last organization, and his rank, just as these data appear on the discharge papers. (Note: The claim number, or C number, is a most important identity, since thousands of veterans have similar names. If you treat a veteran to whom such a number has not yet been assigned, write "C—pending" after his name on your application.)

Be sure to state your diagnosis, even if it is a tentative one. Use the official terminology given in the V.A. handbook ("Manual for Medical Examiners") if you have received your copy*; if not, describe the condition fully. Don't sacrifice

*This manual is now being issued to doctors who participate in the home-town program. Branch offices of the V.A. are handling distribution.

clarity for brevity. Don't use such expressions as "slight temperature" or "poor vision in left eye" when you can give your exact findings in figures.

Describe treatment clearly if any has been given pending authorization. State the number of subsequent treatments, home or office, that you think are indicated. If your estimate proves to be too low, you may suggest additional treatments later. But don't write "indefinite," or some other equally vague term; for such prognoses invariably delay authorization.

In an emergency, you may provide treatment without authorization; but you must apply for it promptly thereafter if you wish to be paid for your services. Fifteen days is the maximum delay allowed. In some states only five days' grace is given.

Sign your application, but be sure to print or type your name clearly below the signature. Many authorizations are held up simply because the V.A. can't decipher the doctor's handwriting.

Bear in mind that the veteran is free to change physicians at will, but only an authorized doctor can charge for treatments. If you are called upon to continue treatments begun by another physician, you—not the veteran—must apply for a new authorization.

MONTHLY BILLS

To get your bills paid promptly by the V.A., be particularly careful about listing thereon the date of each visit and each treatment. The V.A. financial set-up provides for monthly appropriations, and each authorization is based on the funds available within a definite period.

The treatment dates on each bill you submit are carefully checked to be sure they tally with the dates shown on the authorization. If *you* make the same check before you mail the bill, you will facilitate its payment. Conversely, if you try to dodge the issue by omitting all dates, you will gum up the V.A. machinery and your bill may go unpaid for months.

Beside the date of each treatment describe the type of service and the fee. No elaborate description is necessary; a few words, such as "office treatment for malaria," usually do.

Unless the system in your locality calls for a separate bill for each patient, you may list all authorized cases on one billhead. It is not necessary to sub-total the charges for each veteran; one total for the entire bill is sufficient. (One total, moreover, eliminates chances of clerical error and saves checking time in the V.A. office.)

Never list authorized and unauthorized treatments on the same bill. Remember that the authorization is the key to the whole plan, the final and absolute reference for payment of your bill. If you have given services and have applied for but not received authorization by the end of the month, list such services on a separate bill and ask the V.A. to investigate. One bill for both approved and unapproved treatments will almost certainly come back to you unpaid, and you may find yourself involved in long correspondence.

Don't overlook the required certification at the bottom of the bill. The exact wording to be used appears on the face of the authorization or in local instruction sheets.

[PLEASE TURN TO PAGE 78]

The most common form is "I certify that this account of my services in this case is correct and just, and that payment has not been received."

Sign each bill, using a signature that corresponds to the one on your authorization.

Be sure to send the V.A. two copies of every bill (they are counted even before they are read). Keep a third copy for yourself.

Services rendered by an assistant must, of course, be billed in the name of the physician to whom authorization has been granted.

MONTHLY REPORTS

Few doctors have experienced difficulty with the monthly report that the V.A. requires on each veteran-patient. The form provided is fairly simple. You merely list the date of each visit, whether it covers home or office treatment, the patient's complaints, your findings, and a brief description of the treatment given. Here, you may follow the same general rules given before under AUTHORIZATION.

SIMPLIFIED FORMS

In some states, the state medical society has devised a combination form that simplifies the doctor's paper-work. A single sheet serves as authorization form and physician's bill. But the same general rules, as given above, must be followed in supplying the required data.

[EDITOR'S NOTE: MEDICAL ECONOMICS thanks Edmund Eastwood, M.D., Chief Out-patient Administration Division, V.A., for corroborating the accuracy of this article prior to publication.]

"CALL ME AT SEVEN-THIRTY, JOE—SAY IT'S AN EMERGENCY."

Medical Care of Miners Scored By Federal Investigator

Admiral Boone hints at charges to be made in final report

Is there a bad spot in American medicine? Last month it appeared that there might be; but the nation still lacked complete and conclusive evidence of the kind of medical care available to U.S. coal miners.

Several months ago Rear Adm. Joel T. Boone led a public health survey group into the coal mining areas. In December, he hinted at what his report would say. But by early February he had not officially told the Department of the Interior, under whose auspices the survey was made, what he had found.

In December, the AMA House of Delegates heard Admiral Boone, a Navy physician, make a preliminary indictment. He described the lack of elementary sanitary controls in many mining communities: water supplies unprotected, no garbage or sewage disposal, no food handling safeguards, and so on down a long, disturbing list. "Although a number of coal mining communities owned and operated by . . . more progressive companies," said the Admiral, "seem as sanitary as our better cities, they . . . stand out as exceptions."

In Boston the Admiral told doctors attending the Congress on Industrial Health that "Medical practitioners in coal-mining communities pay almost no attention to industrial health matters . . . The mine physician who has taken the trouble to enter a mine . . . to make a cursory occupational study of the men he treats is a rarity." According to National Safety Council statistics, a miner can expect to lose almost twelve days from accidents alone for every 125 days he spends in the pits.

Assuming the soundness of Admiral Boone's initial charges, what would be done about them? Probably nothing until the full findings of the Boone survey had been released and studied. Most of the agencies that could take action naturally wanted all the facts first.

The AMA was not unaware of the problem. Members of the Council on Medical Service as long ago as last fall had met with mine physicians to discuss a new medical and hospital prepayment plan for the soft coal areas. Members of this council had visited the West Virginia fields on several occasions.

The Council on Industrial Health was also actively concerned. But its concern was based more on hearsay than on facts. Once the Boone report was released, the AMA promised to get started.

The United Mine Workers had long demanded better medical care for union members. A year ago John

L. Lewis had won sole control of the money deducted monthly from miners' pay for medical and hospital care. But on how the money would be used, he was keeping mum. By the first of last month he had not even named trustees to administer the union's medical and hospital funds. Asked why, the mine boss said that when the Krug-Lewis coal agreement was signed last May, he had promised Admiral Boone that he would take no action on the disposition of the money until the health survey had been completed.

Nor had mine physicians done much either. Some efforts had been made to improve relations between miners and doctors, but no real progress could be reported. Throughout the West Virginia bituminous area, doctors had offered union leaders the facilities of prepayment medical and hospital plans to replace the contract system. These had been refused, presumably because no policy had come out of Lewis' stronghold in Washington.

Anthracite miners in Pennsylvania did begin recently to enroll in Blue Cross. But the situation in Pennsylvania is different. Most hard-coal miners there live in communities, not in isolated camps of the type found in the bituminous country.

The solution will not be found easily. Blue Cross and voluntary medical care plans may be part of the answer for anthracite miners. But a majority of coal union locals have voted to continue the present contract system under which physicians and hospitals are both paid a fee that is checked off the payroll.

Until this year the usual monthly fee for each miner and his family was about $2 for medical care and $2 for hospitalization. This meant that the contract system had to provide medical and hospital care for five persons (the average miner's family) for $48 a year. Last winter the Associated Mine Physicians raised the medical rate in most districts to an average of about $3 monthly. Hospitals increased their contract rates to the same amount.

Yet both doctors and miners dislike this arrangement. Miners say they lack free choice of doctor. Doctors say they lack free choice of patients. Most mine physicians, says the AMP, are anxious to accept another form of prepayment.

In parts of Kentucky, West Virginia, and Virginia, the contract system has been dropped. Medical care and hospitalization are now on a fee-for-service basis. But mine physicians hardly expect this to work out as a permanent solution.

Delay in the release of the Boone report was only one reason last month why more action was not being taken. The fact that most mining camps are company-owned was another; many physicians, it was said, were afraid to ferret out and talk about public health defects. Local health officials were described as "unbelievably lax." And the Krug-Lewis agreement was due to expire in April. What would happen then was anybody's guess.

There has been no formal denial that medical care in the coal fields is substandard. Admiral Boone warned AMA delegates not to dismiss the coal mine situation as a local problem. Not only mining physicians, he asserted, but every doctor in the country has a stake in the issue. —JOHN A. CONWAY

Need an Intercom System?

Types range from private telephone equipment to simple buzzers

For the doctor who needs an inter-office communication system a wide assortment is available. Included are a telephone-company installation of one or more extensions; a private, independent phone system that may be bought as a unit; the familiar loudspeaker hook-ups; a two-instrument telephone set that operates by flashlight batteries; and the simple buzzer or light systems.

The telephone is sometimes the only effective medium. The companies are installing an instrument (when available) that combines a phone and a miniature switchboard; it's the familiar hand set, with a row of buttons added (at left in cut above). Using it, you can reach your secretary, nurse, or technician without calling the operator. You can make and receive outside calls, too. The new instrument replaces the older device with a row of switch buttons on the side of the desk. A variation is shown (at center in cut) that permits you to ring another phone by dialing rather than pushing a button.

Since the telephone with its built-in switchboard can handle twelve stations, it is flexible enough for all but the largest offices. In cases where it is too small, it can be supplanted by a "private automatic exchange." The exchange consists of any given number of dial phones and a central automatic switchboard. It is not connected in any way with the regular telephone system.

A typical installation of the exchange was made recently in a suite housing two doctors and a dentist. Each has his own private "outside" telephone, with an extension for his secretary. Inter-office communication is carried on through the automatic switchboard. Using the second phone on his desk, each doctor can talk with his colleagues, or with the nurses, laboratory technicians, or receptionist.

[PLEASE TURN TO PAGE 82]

Handitip

Trouble Light

A number of physicians are using a new automobile utility light that requires no dry cells. This lamp plugs into the cigarette-lighter socket. Twelve feet of cord make it handy for motor and tire repairs.

In installing this system, the doctors reasoned that while the private phone system was expensive to install, its upkeep would be low and the new set-up would eliminate two sets of charges: the phone company's monthly fee for a switchboard and the salary of a switchboard operator. Its owners feel that the system will pay for itself in time; and it will of course remain their property.

For a large office the telephone company may recommend a system of phones, each with a separate switch box (at right in cut). Conference calls embracing three or more phones can be made simply by pressing the appropriate keys. The system requires the usual office switchboard through which outside calls are made.

If a loudspeaker arrangement will fit into the scheme of things, a number of types are immediately available. Some require special wiring; others simply plug into electric outlets. The latter type is often badly affected by line noises created by X-ray apparatus, diathermy machines, and the like. Loudspeakers have one big draw-back: They afford about as much privacy as Woolworth's window.

Department stores have been advertising a two-instrument phone set, flashlight-battery-operated, that was developed for the military services and later declared surplus. It is priced quite low, and installation is simple.

For limited purposes, buzzer and light systems have proved effective in many offices. The buzzer needs no description; the physician who uses it simply develops a code by which he communicates with his secretary, or she with him. One buzz may mean, "Send in the next patient"; two, "Get me a credit report on this patient"; three, "How many patients are waiting?"

The light system is a little more difficult to install, but not to operate. It consists of two panels of, say, six small electric light bulbs. Each bulb has its own two-way switch. One panel hangs over the secretary's desk, the other hangs in an inconspicuous spot in the consultation room, where the physician, but not the patient, can see it. Thus the doctor can signal his secretary by lighting the bulbs on her panel one at a time or in any combination. The secretary, likewise, can signal the doctor. Her code may indicate, "Please call the hospital when you get a chance." Or "Better speed up; the place is crowded." Or "I've just checked on that new patient you're talking to; she's a poor credit risk."

Buzzers, unless muted, have the drawback of being noisy. Lights may not always be noticed. Both permit only limited communication. On the other hand, they do make it possible to transmit messages without their being overheard and they are inexpensive to buy and install. —TED CARROLL

A Balanced Insurance Program

It provides for three contingencies: death, disability, and old age

Most personal insurance programs are shockingly out of balance. A man starts with a modest policy or two and adds to them as his income increases. His criterion tends to be, "How much insurance can I afford?" rather than, "How much do I need?"

Professional men tend to purchase a large volume of life insurance, neglecting health and accident insurance and an adequate retirement program. When an attempt *is* made to achieve a balance, it is usually too late.

It is not possible to set up a model, balanced insurance program that will serve the needs of doctors in general. But it is possible to demonstrate, by way of a hypothetical case, the thinking and planning that should precede the purchase of insurance. Thus:

John Blank, a general practitioner, is 40; his wife, 35. They have a son, 5, and a daughter, 3. Doctor Blank has started from scratch to buy insurance that will

¶ Protect his family in the event of his death.

¶ Protect him and his family should he become disabled.

¶ Provide adequate retirement income for himself and his wife.

He considered a number of policies offered him, challenging each with this test: "Does it provide *maximum protection* at the *right time* for the *lowest cost?*" He found that it was seldom possible to gain all three advantages in one contract, but that he could—by making some compromise—evolve a program that would put the premium dollar to its most effective use. Here it is:

LIFE INSURANCE

1. *The need:* maximum protection per premium dollar for his family while that protection is needed most. *The benefit:* $300 a month income for the family from the time of his death until he would have been 65. *The contract:* level-premium, reducing-term life insurance. *The cost:* $640 a year, including waiver of premiums while disabled.

2. *The need:* protection in a lesser sum for his widow after his children become self-supporting. *The benefit:* $67 a month income to his widow, beginning in her sixtieth year, when the $300 monthly income ceases. (The $67 a month will be augmented, as we shall see, by the doctor's retirement program.) *The contract:* level-premium, term-to-65 life insurance. *The cost:* $370 a year, including premium waiver.

3. *The need:* cash for the edu-

How Doctor Blank's Insurance Pays Off

If he dies in 1947, his widow will receive

a) $300 a month for twenty-five years, until 1972.
b) $8,000 between 1960 and 1966 for her two children's college education.
c) $67 a month from 1972, when she will be 60, until she dies.

If he dies in 1957, his widow will receive

a) $300 a month for fifteen years, until 1972.
b) $8,000 between 1960 and 1966 for her two children's college education.
c) $123 a month from 1972, when she will be 60, until she dies.

If he dies in 1967, his widow will receive

a) $300 a month for five years, until 1972.
b) $217 a month from 1972, until she dies.

If he dies in 1977, his widow will receive

a) About $200 a month for fifteen years, or until she is 80.
b) $3,700 in cash.

cation of the doctor's children if he should die prematurely. *The benefit:* a fund of $8,000 to provide each child with $1,000 for each college year. *The contract:* twenty-year-term life insurance. *The cost:* $130 a year, including premium waiver.

4. *The need:* an unencumbered home. *The benefit:* payment of the unamortized part of the mortgage at the doctor's death. *The contract:* mortgage-amortization life insurance. *The cost:* an $830 lump sum for a $10,000 policy. (Note: The doctor regards this as an investment in his home and has paid the entire cost out of current cash.)

HEALTH AND ACCIDENT

5. *The need:* income if Dr. Blank is disabled for a prolonged period. *The benefit:* $400 a month for a maximum of eight years and four months. *The contract:* noncancelable health and accident insurance, expiring at age 60. *The cost:* $270 a year.

RETIREMENT

6. *The need:* adequate retirement income. *The benefit:* $200 a

month to the doctor from his sixty-fifth year to his death. If he dies before he has collected his monthly income for twenty years, his wife will receive $200 a month for the remainder of the twenty-year term. If he dies before drawing any retirement income, the fund built up by his premiums will be paid to his wife in the form of monthly income. *The contract:* optional retirement annuity (twenty years certain). *The cost:* $1,270 a year. (A premium waiver has not been included in this program of pure savings since it would be uneconomical.)

COST

The total cost of Doctor Blank's program is $2,680 a year, apportioned as follows: life insurance, $1,140; health and accident insurance, $270; retirement annuity, $1,270.

The cost is high, but so is the degree of protection; and that's what the doctor set out to get. About half the outlay represents pure savings; and that part of the program can be suspended if the physician's income should nosedive. In any event, he has made an economical selection of policies. A more detailed examination will demonstrate why.

In making his decision to adjust protection to the need, he chose term insurance rather than straight-life. His level-premium, reducing term insurance, providing $300 a month for his family, is pure protection over the critical years. The policies are free of features that increase premium cost without increasing protection, *e.g.*, cash values and loan privileges. He reasons that such features are never bonuses but are made possible by the insured's own money, paid in the form of higher premiums. He also reasons that it is more economical, premium-wise, to set up a separate retirement annuity program. Thus, if the doctor lives to 65, his first policy of term insurance expires and he gets no return of any kind. If he dies before that, however, his beneficiaries will receive the following aggregates of income:

Age at Death	Monthly-Payment Aggregate
40	$90,000
45	72,000
50	54,000
55	36,000
60	18,000
65*	10,800

Doctor Blank's No. 2 contract is designed to provide a minimum income for his widow when she reaches 60 and the first contract has ceased to pay benefits. This income will be considerably augmented by returns from the retirement annuity if the doctor does not live to draw the income himself. The second term contract hinges on age 65 also; the $67 monthly income is payable to the doctor's widow only if he dies in or before that year. But, in contrast to the first term contract, it provides that if Doctor Blank lives to 65, he has these options: (1) He may elect to pay no further premiums and still be insured for $15,000 until he is 74 1/3 years old; (2) he may continue to pay full premiums, minus dividends, and be insured for $7,500 for the rest of his life; (3) he may convert to a paid-up contract in the amount of $3,700, also effective for life; (4) or he may

*Income is paid for three years.

surrender his contract for $2,835 in cash.

The doctor's third contract—to provide funds for his children's education *if he dies before they are ready for college*—is effective for twenty years. If he educates his children out of his income, but dies before the twenty-year term has expired, the $8,000 proceeds of the policy will go to his widow. If he lives beyond the twenty-year term, the policy will expire and have no value.

Again, this is pure protection—in this case, for his children. If the doctor lives to see his boy and girl through college, he will have to find some other means of paying their way. For one thing, he is weighing the possibility of setting up an insurance endowment program for each child; it would return $1,000 a year to each for four college years. Assuming that the children would enter college in their eighteenth year, the endowment maturities would be as follows: for the boy, $1,000 a year in 1960, 1961, 1962, and 1963; for the girl, $1,000 a year in 1962, 1963, 1964, and 1965. The odd-year endowment policies necessary to make this possible would cost, with premium waiver, about $550 a year. If the doctor is able to swing this $550 premium along with the $2,680 premium for his other insurance, then funds for the education of his children will be assured whether he lives or not.

The doctor's home cost him $15,000; of that, $10,000 remains unpaid on a monthly amortization mortgage. His mortgage policy will pay off the unpaid part at his death, leaving an unencumbered home for his family. While he chose to pay for this policy in a single premium of about $830, he could have spread the cost over a period of up to eight years.

The health and accident contract, which pays disability benefits for a maximum of eight years and four months, is practical, if not perfect. Relatively few men are disabled so long; fewer still survive a disability that persists so long. True, the physician could have purchased lifetime disability protection, but only by buying a large amount of straight life insurance (the prevailing ratio is $5 a month disability income for every $1,000, face value, of life insurance). He would have had to purchase $80,000 of straight life to gain $400 a month of disability protection. Premiums would have been far above those to which he is now committed.

In setting up his insurance program, our hypothetical physician has been careful to divorce his retirement annuity from his life insurance. He had a number of reasons for making this decision, but his principal one was this: If, in the event of a depression, his income is cut drastically, he may suspend his annuity program and keep his life insurance.

IF HE DIES AT 50

As a means of judging the adequacy of Doctor Blank's program, assume that he dies at 50. His wife is then 45; his children are 15 and 13. Here is what happens:

1. Monthly income payments of $300 begin. These payments will be made for fifteen years (or until the doctor would have been 65).

2. From $8,000 of 20-year term insurance, the company will advance $1,000 a year to each child

during his or her college years. (In the event that either child does not enter college, the funds for that child's education will be paid to the widow as monthly income.)

3. The balance on the home mortgage is paid off.

Thus, the family is well provided for in the critical years when the children are being reared. In fifteen years, they will be self-supporting; their mother will then require less income. When the widow is 60 (the doctor would then have been 65), the $300 a month income ceases. Now Mrs. Blank begins to receive $123 a month—$67 from the second policy plus $56 a month from the fund built up by premiums the doctor paid on his annuity contract. In ten years he accumulated about $12,500 in that fund. In purchasing the contract, he stipulated that if he died before 65, the accumulated funds would be paid to his wife in the form of lifetime monthly income beginning when she reached 60.

IF HE DIES AT 60

To continue our analysis, assume that Doctor Blank dies at 60. His widow will then receive $300 a month for five years. In addition, she will be paid $8,000 in cash under the twenty-year term policy, since the children were educated during her husband's life. Five years hence the $300 monthly income will cease, to be replaced by $67. But this will be augmented by $150 a month income for life from the retirement annuity, now totaling about $30,000. (Mrs. Blank would receive slightly more on a twenty-year, rather than on a lifetime, basis.)

IF HE DIES AT 70

Finally, assume that Doctor Blank dies at 70 (his wife is then 65). His first contract ($300 a month) expired when he was 65, at which time he converted his second term contract ($67 a month) to a paid-up policy for $3,700, which sum now goes to his widow. At 70, he had been drawing about $200 a month retirement income for five years. His widow will continue to receive the same sum for fifteen years, or until she is 80.

—W. CLIFFORD KLENK

House Committee

My wife is chairman of the health division of our local council of social agencies. One of her duties is to receive reports on houses of prostitution. These reports come in code and must be interpreted with a separate key.

Not long ago at a directors' meeting she was asked some question about the source of her prostitution data. With no thought of double-talk, she explained that her information was gathered "by specially trained undercover men." The male members of the board immediately began to chuckle, and my wife realized she had said the wrong thing. She didn't help matters by adding, "I can give you the report on these houses, but I can't supply a key."

—RALPH W. HOFFMAN, M.D.

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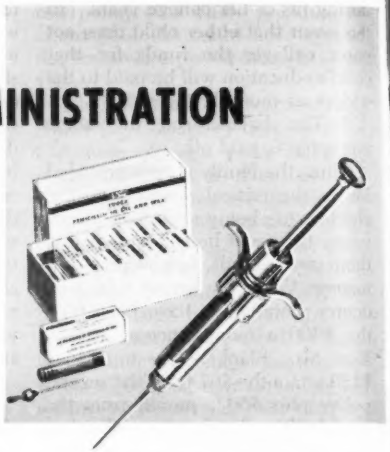

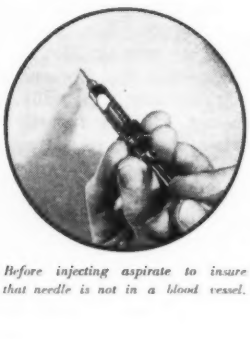

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Your Bill in Auto-Crash Cases

How to collect after rendering emergency treatment to out-of-town patients

With highway travel back on a pre-war basis, the mounting number of accident cases is having an inevitable result: more hard-to-collect accounts on physicians' books.

Obviously, you don't count the cost when there's an emergency demand for your services. Yet without diminishing your professional stature one iota, you can adopt practical means of collecting from auto-accident patients. Here are some suggestions:

Your typical auto-crash patient is usually a complete stranger. He may even live several hundred miles away, in another state. That makes bill-dodging relatively easy. If he was not responsible for his accident, he is reluctant to pay the doctor's bill and may stall in the hope that you'll collect from the other fellow.

Many a fee has been lost because the physician did not obtain sufficient and authentic data as soon as possible. Bills mailed to addresses given by crash victims have often been returned unopened, and stamped "Addressee Unknown."

The persons involved in an accident may be your primary source of information. Check promptly the facts obtained from them. State laws require immediate reports of all motor-vehicle accidents; police and highway authorities, to whom you, as the attending physician, must report anyway, can usually furnish correct names, addresses, and places of employment.

A policeman can obtain a person's true identity much more readily than a doctor or nurse can. An officer at the scene of an accident may therefore be a real help. If, however, you find none there when you arrive, be sure to jot down the license number of the car or cars involved. Ask to see the drivers' registration cards and copy from them the names and addresses.

If the injured person is a married woman, get the name of her husband and his place of employment; if a child, get the parents' names and address.

Mail bills for accident work promptly. Don't wait till the end of the month. Your patient may be insured against accident, and your bill should be on hand in case of immediate settlement. Delay in sending your bill may mean nonpayment, since the insurance money may be quickly spent.

If the bill isn't paid promptly, send another at an early date. Some physicians have found it effective to append a note, saying in effect: "Since you are not one of my regular patients, it is requested that

this bill be paid within ten days."

In some cases, the person responsible for the crash may be willing to make an on-the-spot settlement. If you encounter a driver who seems inclined to "set things straight," remind him that standard accident policies cover emergency treatment even when the policyholder isn't at fault. Often such a person will then settle in cash, knowing that he will be reimbursed by his insurance company. Even if he isn't insured, he may be willing to settle then and there.

If your patient has to be hospitalized, ask him, once he's out of danger, how he wishes to pay for treatment. Stress cash settlement. If he can't settle immediately, ask him to sign a promise to pay, explaining that you use this procedure routinely.

Such a promise, while not a legal necessity, exerts a strong psychological influence. It can be a short, simple statement.

Because every accident is a potential court case, your medical record should be compiled with scrupulous care. Be sure to show the exact nature of the injury and details of the treatment given, advised, or refused. Every fact will be needed if a court has to decide on the reasonableness of your fee.

In some states, lien laws take care of the real dead-beat, the fellow who demands expert medical care, collects indemnity or damages, and then pooh-poohs his obligation to the doctor. In one state, for example, the physicians' lien law provides that 25 per cent of any amount due a crash victim must be earmarked for the attending doctor. If the 25 per cent exceeds the doctor's bill, the excess reverts to the patient. Medical societies have been instrumental in getting such legislation enacted.

In some localities, traffic rules provide that a physician's bill may be added to any fine imposed on a patient who is haled into court for reckless driving.

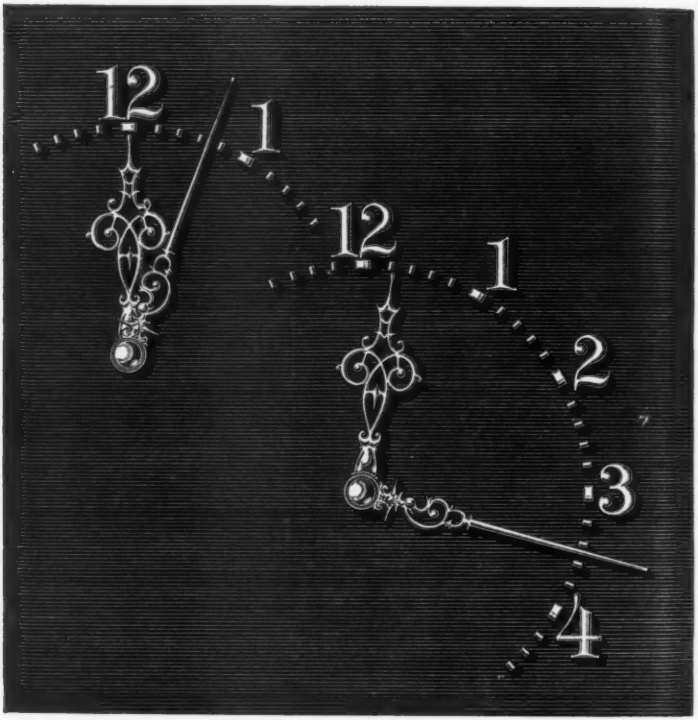
It is well to bear in mind that the patient is legally responsible for the medical bill unless, of course, you have a definite contract with someone else for his care. This holds true even if the injured person is unconscious when you are called to attend him and hence is unable to assent or protest.

If a lawyer phones you to make an appointment for an injured client and says, "Send the bill to me," ask for written confirmation showing that he has personally assumed the responsibility; otherwise, you may find yourself caught in a game of buck-passing. Although the lawyer says, 'I'll pay you when I get my fee," the person you treat remains legally liable.

Even if an injured plaintiff receives a substantial settlement in court, neither the defendant nor his insurance carrier is bound to foot the medical bill. The patient, and only the patient, is liable.

In any case involving a patient and his lawyer, be sure to send a copy of your bill to the attorney. Ask him to acknowledge receipt. Your statement thus becomes a part of the lawyer's case record, and he will have it on hand as an important reminder should an out-of-court settlement be suggested. Without it, the attorney may well forget to include your fee in any final settlement. —BURTON COOK

A minute saved=



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Launching a Private Medical Group

How professional and administrative services can be organized efficiently

Three physicians, established in their community for many years, have decided to form the Valley Medical Group. Through it they hope ultimately to offer all general and specialist care in the office, home, or hospital on a fee-for-service basis. Two of the men are general practitioners: Doctor Abbott, who also does obstetrics, and Doctor Berry, a partial specialist in ENT. The third, Doctor Carr, is a full specialist in surgery, certified by his American board.

The three practitioners have been mulling over the prospect of group work for several years. They have sounded out other established men in the community about joining them. All have declined. Therefore, the partners have decided to take in three younger men, not long out of their residencies, on a salary basis. Eventually, perhaps in five years, they hope to make the new men junior partners. The three juniors have been selected after careful study of their educational records and of their personalities. Everything indicates that they will not only be good doctors but congenial colleagues.

The junior men are Doctor Darrow, who will specialize in pediatrics; Doctor Evers, an internist; and Doctor Fowler, a roentgenologist. Doctors Darrow and Evers will seek certification; Doctor Fowler, who has been doing hospital X-ray work for a number of years, has already achieved it. His special interest is cancer, although in the group he will do general X-ray work, both diagnostic and thera-

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► Increased interest in group practice led MEDICAL ECONOMICS to undertake a broad study of the subject. Almost every known group in the U.S. has been contacted. Data collected are now being presented in a series of articles.

For the purpose of this series, group practice is defined as the provision of medical services, both diagnostic and therapeutic, by a number of physicians working in systematic association, with joint use of equipment and technical personnel, and centralized administrative and financial organization. The reference groups (*e.g.*, Lahey, Mayo) and the diagnostic groups (*e.g.*, Johns Hopkins, Mount Sinai) are, for obvious reasons, excluded from consideration.

In this article and several to follow, the set-up of a hypothetical group will be described.

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peutic. For the time being, he will be on a part-time basis.

Thus, the group from the start will offer the services generally considered essential in even a small organization. Later, the partners hope to add other specialties.

Doctor Abbott, will, as soon as possible, step out of general practice and do only obstetrics. Doctor Berry, seeking certification, wants to devote all his time to ENT. So it is evident that several more G.P.'s or internists will have to be added in time. The practices of the three partners, it is assumed, will largely carry the group for several years, with the result that their personal incomes will suffer somewhat during that period.

BASIC PLANNING

The partners have completed about six months of preliminary research and planning. Each has visited a different, well-known group and studied its organization and operation. In addition, the partners have discussed the practical aspects of their proposed venture with business men and bankers. In fact, they have established among these men a sort of informal advisory committee to which they can take specific problems.

In their study of other groups the partners have learned that a successful organization has three attributes: (1) professional balance, (2) economic balance, and (3) the prospect of perpetuation.

Professional balance, means simply that there must be enough general physicians and specialists in the group to offer the patient optimum service. That balance isn't easily achieved in a new group. The partners found that most now-flourishing groups started out in modest fashion and expanded. As more patients were added to the roster, the participation of more specialists followed.

In the literature on group practice, the partners discovered much theorizing on the physician-patient ratio, but little of practical use in planning. The most applicable advice they ran across was a warning offered by Dr. Franz Goldmann in an address before the New England Pediatric Society:

"It would be a grave mistake to place all emphasis on specialists' service . . . The essential point is smooth cooperation of general practitioners and specialists, enabling the general practitioner as well as the specialist to realize his ideal possibilities, so that the general practitioner can truly be the family doctor, the specialist can complement the general practitioner, and the patient can receive the optimum in quality, efficiency, and economy of service."

Economic balance means that every participating physician should (1) receive a just return for his work and (2) be satisfied that he is getting a just return. In their research, the partners found that the first condition is much easier to achieve than the second. For that reason, they are carefully working out a precise method of distributing income after expenses have been met and funds have been established for contingencies.

So that the group may survive the death or withdrawal of its founders, a two-part plan has been evolved. This assures the perpetuation of the group by providing for its continuance under carefully

drawn up articles of copartnership and by segregating its physical assets—buildings and equipment—in a holding corporation.

ADMINISTRATION

The Valley Medical Group will be under the control of an executive committee. At the start, the committee will consist of three members, the founders, each with an equal vote. Later, as the group takes in additional partners, the executive committee will be elected yearly by secret ballot, with senior men having one vote and junior partners a half-vote.

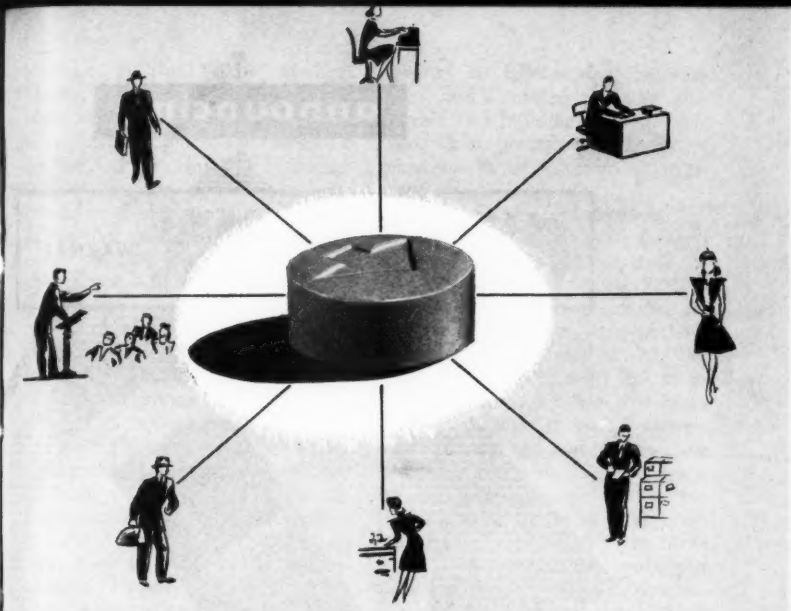
The executive committee will establish general policies and be the final judge of major issues. But it will not attempt to plan or supervise all the routine activities of the organization. To a business manager it will delegate control of fiscal administration; to each department head, full professional control of his department. There will be no over-all medical director.

FEES

After weighing advice, pro and con, the Valley Medical Group has decided not to establish any fixed schedule of fees. To that rule there will be two exceptions: (1) The fee per visit of the G.P.'s will be set at the rate prevailing in the area; (2) the group will accept the fee schedule of the state medical society's prepayment plan for persons under the prescribed income limit. Otherwise, each specialist will jot down his charge for a consultation on a form that will go to the business office. The business manager will handle all billing and collections. No physician will discuss the size of fees or the method of paying them with a patient. The business manager will have full authority to adjust any bill to the patient's ability to pay or to cancel it entirely in the case of an indigent.

This method, the partners have found, works extremely well in other groups. The manager is not inhibited, as is the doctor, in discussing financial matters. He uses the facilities of credit bureaus and makes his own credit investigations when necessary. He helps the patient budget his payments over a period of time and requires him to stick to that arrangement. Meanwhile, the doctor can concentrate on the practice of medicine.

Such an arrangement gives everyone an economic advantage. The doctor collects for his services; the patient pays no more than he can afford and remits on a convenient basis. He will have still another ad-



Little tablet, you've had a busy day!

Yes . . . like all Anacin tablets, it's been through the proverbial mill.

Tested. Tested again and again. Scrutinized and examined. Then tested some more . . .

In short, the most exhaustive investigations known to modern science have verified this Anacin tablet's uncompromising quality, uniformity and dependability.

Hence, when it is employed to allay the discomforts of dysmenorrhea, simple headache or minor neuralgia, it can be relied upon to act in the best tradition of the Anacin family—which is quick, effective relief.

Fast-Acting . . . Long-Lasting

WHITEHALL PHARMACAL COMPANY
22 East 40th Street, New York 16, N. Y.

WHITEHALL

vantage in the Valley Medical Group, for the partners have decided not to charge for a specialist's consultation when one is requested by the G.P. to clinch a diagnosis. Only when the patient has been turned over to a specialist for more exhaustive examination and treatment will he be billed. This arrangement has meant little or no financial loss for groups that have tried it. It also helps avert any misconception in the community that the group "puts the patient through the mill" to run up a big bill.

QUARTERS

Finding quarters for the Valley Medical Group has been a problem. Each of the partners' present offices is inadequate. The group plans to erect its own building later; but right now it must accept a compromise. Thus, it has taken an option on the second floor of a two-story commercial building near the center of the shopping district; the ground floor is occupied by retail stores.

The site has a number of advantages:

It has windows on three sides, so each of the six group physicians can have a suite of two rooms with natural light. Skylights illuminate the central section, which will be devoted to laboratories, business office, and a retiring room for personnel. The building is of the loft type, which permits the erection of partitions in any desired arrangement.

There are also disadvantages:

The building has no elevator, which means that arthritic and cardiac patients will be forced to climb a flight of stairs. It is situated on a congested street, making parking a problem. The rent is high because the building is in the shopping district, a situation that gives the doctors little or no advantage. The entrance hall and stairway are nondescript and shabby; the group will have to alter and redecorate them at its own expense. The heating system is adequate, but there is no air-cooling system, and open windows admit considerable noise. No hospital is nearer than fifteen minutes by automobile.

The group's long-range building program is of course aimed at overcoming these disadvantages. The pioneer groups have warned that the need for physical expansion is likely to outrace any plans made for it. More than one group has found that its building, which seemed more than adequate in the planning stages, has become hope-

lessly overcrowded within a comparatively few years. So, in discussions with their architect, the partners have laid down a few principles:

¶ The building should be within five minutes' drive of the hospital in which the physicians will do most of their work.

¶ It should be in a quiet residential area (if zoning laws permit) rather than in a congested, noisy business district.

¶ If possible, it should be near a main bus line.

¶ The structure should be on a large plot of ground, with ample room for the parking of patients' and doctors' cars.

¶ It should be planned for upward, rather than outward, expansion; engineering calculations and architectural design should allow for the addition of two or three floors.

¶ A separate ambulance driveway and receiving room should be provided.

PERSONNEL

While the Valley Medical Group has decided to employ a business manager, it has not yet selected anyone for the post. Meanwhile the partners have drawn up the following plan for the business administration of the group:

In position, responsibility, and income, the business manager will be nearly on a par with the partners. As a result of their research, the three colleagues have concluded that it would be a mistake to hire any but the highest type of executive. Thus they are looking for a person with these qualifications:

¶ A sound background in office management and business administration.

¶ An intimate knowledge of accounting, preferably in public accounting.

¶ Ability to deal with personnel.

¶ A thorough knowledge of credit and collections.

¶ Infinite tact in handling the intramural affairs of the doctors and their relations with the profession and the public.

All this, of course, adds up to the type of man who is in demand everywhere. Thus another qualification, a knowledge of medical economics, can only be hoped for, not insisted upon.

The business manager will be in full charge of all nonprofessional personnel. This will include a bookkeeper, a receptionist (who will have minor clerical duties), a switchboard operator-typist, medical secretaries (two at the start), a cashier and charge clerk, and a medical librarian.

Nurses, laboratory technicians, and professional personnel generally will be under the control of the executive committee until the departments have been fully set up and other administrative committees organized.

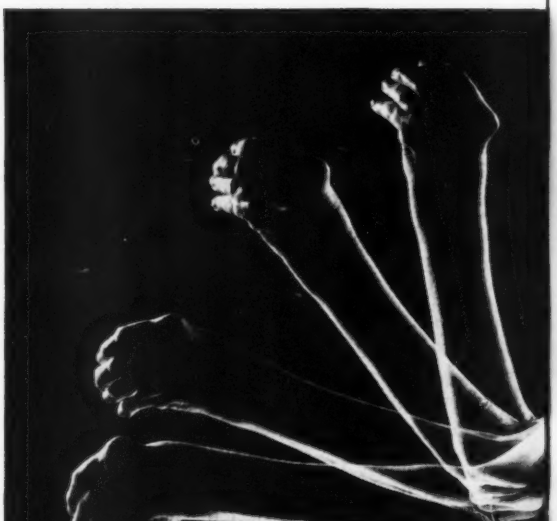
EQUIPMENT

Much of the partners' present equipment will be usable in group practice. However, some of it will be sold and additional items purchased. As a preliminary step, the group is having an appraisal made of all equipment now owned. This will be useful in establishing the amount of each partner's financial investment in the group.

—ROSS C. MCCLUSKEY

[*To be continued*]

what is the objective evidence of



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ce of Steroid Therapy in Arthritis?

In order to properly evaluate the patient's response to steroid therapy with Ertron, the objective findings of the investigators should prove of interest.

OBJECTIVE RESULTS WITH ERTRON

Swelling—Decreased swelling[1] was early reported as evidence of favorable action of Ertron. X-rays demonstrated this to be due to diminished joint effusion[2] and reduced soft tissue swelling.[3]

Strength—The systemic action of Ertron is reflected in the improved muscular tone,[3] which is determined by recording the grip dynamometer readings[4] during the course of therapy.

Mobility—Increase in the angle of passive and active mobility[5,6,7] of affected joints in Ertronized patients is measurable.

Weight—In thin, asthenic individuals, weight gain[8] is evidence of the systemic action of Ertron, and usually accompanies increased appetite.

ERTRON
STEROID COMPLEX, WHITTIER

The distinct therapeutic action of Ertron is accounted for by its unique chemical composition. The method of activation employed in the preparation of Ertron produces a complex containing hitherto unrecognized factors which are members of the steroid group. The isolation and identification of these substances in pure form further establish the chemical uniqueness and steroid complex characteristics of Ertron.

Physician control of the arthritic patient is essential for optimum results. Ertron is available to the patient only upon the prescription of a physician.

Supplied in bottles of 50, 100 and 500 capsules. Each capsule contains 5 mg. of activation-products having antirachitic activity of fifty thousand U.S.P. units. Also, Ertron Parenteral in packages of six 1 cc. ampules. Ethically promoted.

Ertron is the registered trademark of Nutrition Research Laboratories.

NUTRITION RESEARCH LABORATORIES • CHICAGO

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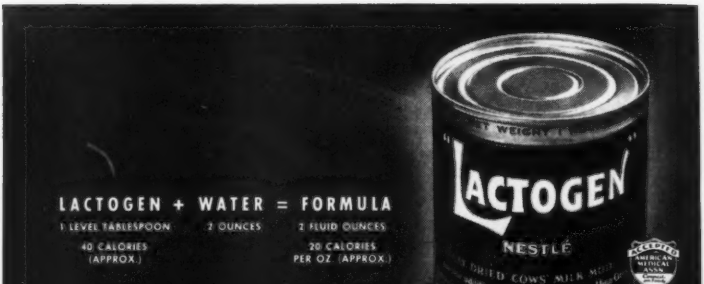

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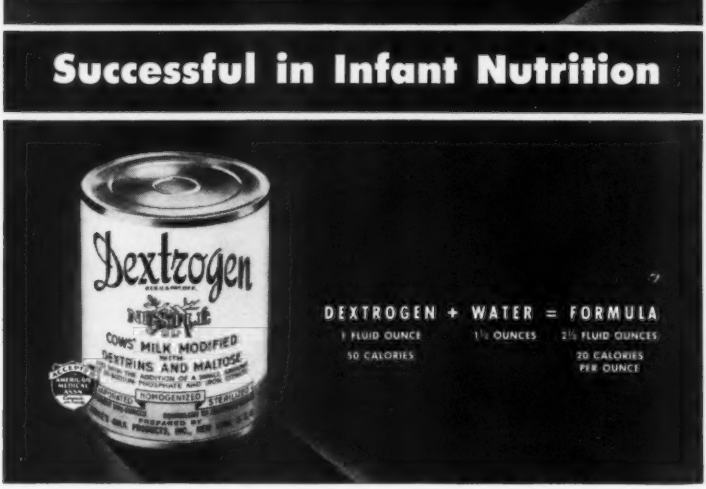

No advertising or feeding directions, except to physicians. For feeding directions and prescription pads, send your professional blank to

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155 EAST 44TH ST., NEW YORK, 17, N. Y.

CALLING MISS BREDOW!

Your office trouble-shooter suggests how to schedule house calls

Q. Patients' requests to have the doctor call at their homes interfere frequently with office appointments. How should I handle this problem?

A. When home calls are required, as in the case of a general practitioner or pediatrician, a fixed time should be set aside for them each day. These hours should be kept apart from office appointments, except when the appointments are for injections or physical medicine treatments that the medical assistant herself can administer.

When a request for a home visit comes in during office hours, the way to handle it depends on where the doctor is at the moment and on the condition of the patient. It is important to inquire about the latter situation. The information to be ascertained by the secretary is:

Name of patient; address (it is advisable to ask how to reach the house if the neighborhood is a strange one); telephone number; condition of patient; and whether the person calling is the patient.

If the case does not appear urgent —and most such calls concern only minor illnesses—the appointment should be made for a time that does not conflict with office hours. For example, if the call comes in the morning, the doctor may wish to visit the patient before lunch or before returning to the office from lunch. If the call comes later, he will often prefer to visit the patient's house on his way home.

Make sure you have a list of patients the doctor is visiting on his regular rounds. It should show their telephone numbers, the order in which the doctor expects to visit them, and the approximate time for each visit. Thus the secretary can figure out quickly where the doctor can be located and how long it will take him to reach the patient who is calling, if only by phone.

If the call is an emergency one, such as an accident, a heart attack, or a stroke, the doctor may have to leave the office. His other patients may have to wait. Explain the emergency to the patients and inquire

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▶ Questions from physicians and secretaries about business procedures in the medical office are answered here as space permits by Miriam Bredow. Miss Bredow is author of "Handbook for the Medical Secretary" (McGraw-Hill) and Dean of Women, Eastern School for Physicians' Aides. In private life, she is Mrs. Heinrich Wolf, wife of a New York physiatrist.

Handitip

Check Perforator

A useful piece of pocket-sized equipment is a check-perforator. To prevent fill-ins or alterations on checks, this pen-shaped, aluminum gadget punches small holes through the paper. At a time-cost of about two seconds, your secretary can make a check tamper-proof.

whether any of them would prefer to return the next day. Make other appointments for them as soon as time is available.

Anyone who calls in an emergency is probably very excited; he is apt to forget the most important items. It is up to you to remain calm and to ask for exact information.

Patients who are ill at home also want the doctor to come as soon as possible. Be sympathetic, tell the patient that you will locate the doctor and that he will get in touch with him as soon as he can. Do not promise a definite hour unless you are sure the doctor can be there then. Give an approximate time, but allow more time rather than less, so that the patient will not become impatient.

You can see from the foregoing how important it is that you know at all times where the doctor is. Whenever possible, arrange with him to leave a telephone number at which he can be reached or to call the office at intervals. In the latter case, be sure to have near the phone a record of all messages received so that you don't keep the doctor waiting when he calls. —MIRIAM BREDOW

"If you come up to see me sometime, doctor— be sure to bring D-P-T★!"

Where else *but* in D-P-T—Cutter's combined vaccine—will you find all these distinct advantages:

Phase I pertussis organisms grown on human blood — to avoid the danger of sensitization to animal protein. It also assures high antigenicity of pertussis organisms.

Diphtheria and tetanus toxoids highly purified—so that each cc. contains well over one human dose.

A formula which supplies in each cc. *40 billion Phase I pertussis organisms—plus the purified toxoids*—permitting a dosage schedule of only 0.5 cc., 1 cc., 1 cc.

You'll find more advantages in another Cutter product—D-P-T (*Alhydrox*). Not only does it provide higher immunity levels than alum precipitated vaccines—it reduces to a minimum such side reactions as persistent nodules and sterile abscesses. Presents less pain on injection, too, because of a more normal pH.

Try Cutter D-P-T—Plain or Alhydrox—you'll be pleased with the results.

★*Cutter's brand of combined diphtheria, pertussis and tetanus antigens.*

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For your "anxious-to-do-right" parents, Cutter offers an informative new booklet—"How to Prevent Diseases of Children." Write us for the gift copies you'll need.

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Fine Biologicals and
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8 OUT OF 9 MIGRAINE PATIENTS COMPLETELY RELIEVED BY NAOTIN

(75% success in all types of headache treated)

A recent report[1] on the treatment of 100 cases of severe headache, including migraine, emphasizes the clinical value of NAOTIN.* Closely following the characteristic flush and heat sensation due to the peripheral dilatation produced by a 100 mg. dose, given intravenously, complete relief of headache was achieved in 75 cases, and partial relief in all but three of the remaining 25 cases.

In other types of headache, as well, the authors obtained "excellent results" with NAOTIN. All 13 patients with post-spinal-tap headaches were completely relieved, as were 42 out of a group of 57 idiopathic cephalalgias. Side effects were minimal and infrequent, and recurrences were noted in only 22 patients.

A clinical trial will prove the value of NAOTIN in your own practice. For further detailed information, write to the Medical Service Department, The Drug Products Co., Inc., Passaic, New Jersey.

1. Goldzieher and Popkin, *J.A.M.A. 131*:103, 1946

NAOTIN

"Drug Products"

*Brand of sodium nicotinate solution

★ IN THE SERVICE OF MEDICINE FOR OVER THREE DECADES ★

How to Win the Patient's Confidence

Demonstrate that you know more about the case than the patient does

A woman frightened about her condition comes to you for treatment. She has no reason, other than your degree, for trusting in your ability to understand her trouble. Do you know how to make her feel more hopeful, how to inspire confidence in your professional skill?

Several basic principles are worth reviewing:

Impress her with the fact that you are sympathetic and confident, that she can depend on medical science to give her relief. In addition, show her that you know far more about her case than she does, even about the aspects that she supposes are her particular secret.

There are few surer ways to win a patient's confidence in your ability than to tell her something *she* knows but doesn't think *you* know.

This was demonstrated in the office of a general practitioner in a small Midwestern town. A young woman, in a state of intense nervous excitement, asked to see the doctor. Her eyes were protruding. There was a perceptible throb in her throat. Her movements were quick but unsure.

"Doctor," she exclaimed, "I'm frightened!"

"What about?" asked the physician.

"About myself," she replied. "Let me tell you what happened on the way to your office. I live on the north side of town. Today I walked down here. When I got to the railroad crossing, a train was approaching and I had to wait until it passed."

"Wait a moment. Let me finish it for you. Weren't you going to tell me that you had an almost irresistible urge to throw yourself in front of the train?"

"Why, yes!"

"And weren't you going to tell me that you don't know why you felt the urge, but that something seemed to draw you toward the tracks against your will? You may even have had to clutch tightly to a post to hold yourself back."

"I did. But how did *you* know?"

"I've heard the same story before. You're not the first woman who has wanted to throw herself under a train."

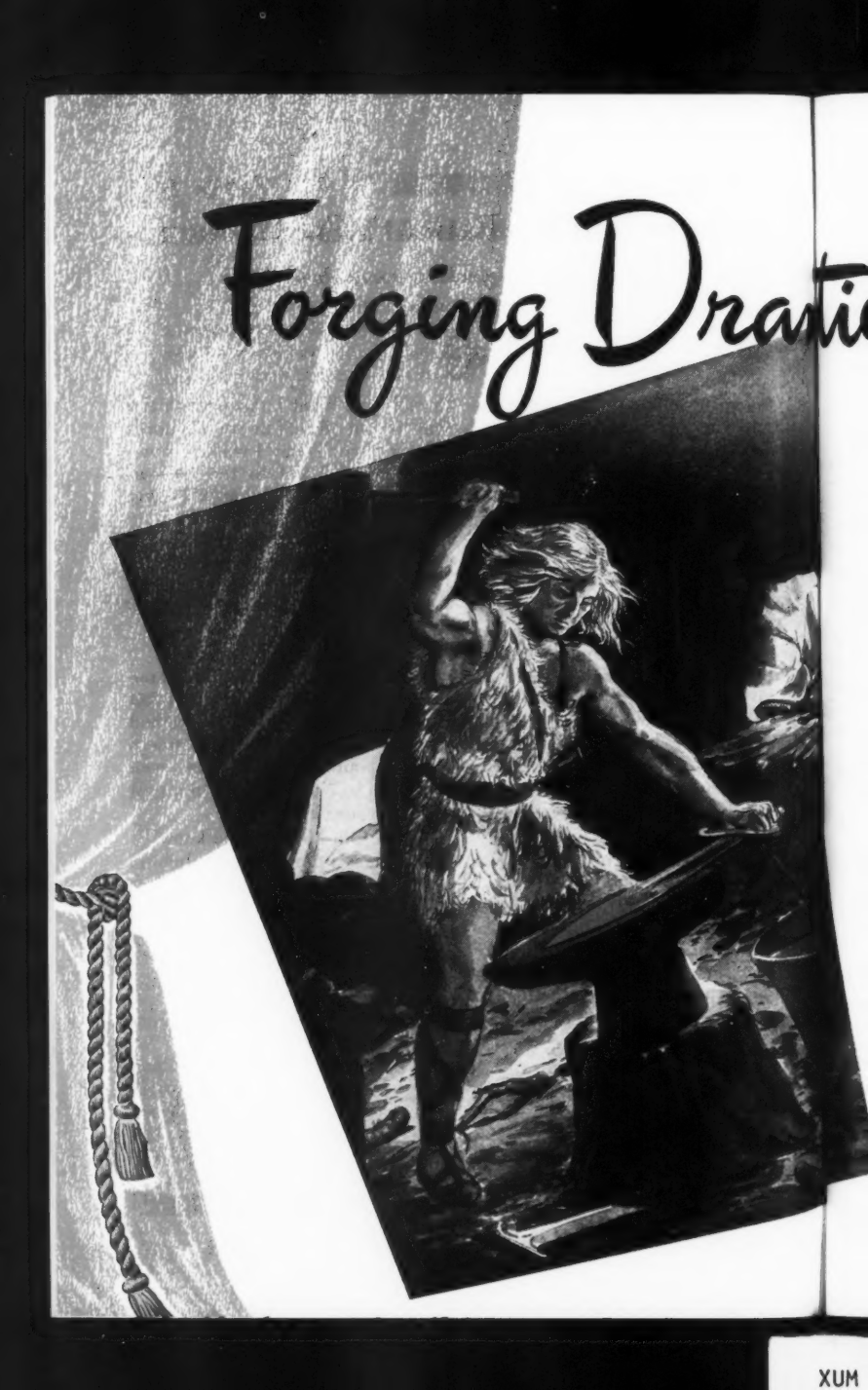
"But I don't want to commit suicide; I want to live."

"Of course you want to live."

"But I get so nervous that I seem to go all to pieces."

"Yes. I know just what it's like. Your heart seems to race faster than your strength can stand. And there's that throbbing in your throat. And your eyes seem strained. Am I describing it correctly?"

[PLEASE TURN TO PAGE 114]


Forging Dra

...atic Effects . . .

IN IRON DEFICIENCY ANEMIAS

In the anemias following chronic blood loss, in "idiopathic hypochromic anemia", in chlorosis, in the hypochromic anemia of pregnancy and of infants, and in hookworm anemia—results from the administration of iron (as contained in Bironex) often may be "dramatic".* • Available as a singularly palatable syrup (ideally suited for administration to infants and children), and also in tablet form, Bironex combines ferrous sulfate (the well tolerated, easily assimilated, small dosage form of inorganic iron), with thiamine (so valuable for restoring the desire for food in anemic patients). • Outstanding in stability and economy, Bironex has the additional advantage of being a non-alcoholic preparation which is non-corrosive and non-irritant to the teeth.

FORMULA: Each teaspoonful Bironex Syrup contains: ferrous sulfate 2.7 grs., thiamine chloride 1 mg. Each Bironex Tablet contains: ferrous sulfate (exsicc.) 3 grs., thiamine chloride 1 mg.

**Wintrobe, M. M., Clinical Hematology, p. 263, 1942.*

A. H. ROBINS COMPANY · RICHMOND 19, VA.

Ethical Pharmaceuticals of Merit since 1878

BIRONEX

a Robins Triumph

"Yes, yes! What is it?"

"It's exophthalmic goiter."

"How horrible!"

"No; it can be cured. You recall that I told you I had heard before about this impulse to leap under trains? Well, the woman who first told me that is now as well as I am. Not only is she in perfect health, but all trace of nervousness has disappeared. She is calm and poised, just as you are going to be."

At that point the patient, although she didn't realize it, had started to improve. The easing of her mind at the first interview was as important a step as any item in the long course of treatment.

In many a case a woman's knowledge that she is sick makes her all the more sick. She fears that the children are not being cared for properly while she is helpless; she doubts that the doctor fully understands what is the matter with her; she is afraid she is getting the wrong treatment; she worries about the expense of her illness; she frets at the slowness of recovery. She may be excitable, or listless, or despondent, or any one of a hundred other things. In virtually every case, however, the physician can instill confidence.

In the case of the woman with exophthalmic goiter, her physician didn't wait until fears of his ability had been expressed, or even hinted at. He scotched them at the outset by showing the patient that he knew so much about her condition that he was even aware of the suicidal urge.

If someone were to compile a set of rules for the physician to apply in inspiring confidence, they would read something like this:

¶ Have confidence in your own ability.

¶ Say something to show the patient you are confident.

¶ Prove to the patient that you know more about his case than he does.

¶ If necessary, defer judgment when making an examination, but don't show hesitancy or indecision.

—M. WRIGHT

Here a Johnson's BACK PLASTER is being applied for low back strain.

Have you considered these advantages of Johnson's BACK PLASTER?

FROM the viewpoints of medical efficacy and practical convenience, these plasters merit your consideration for backache ailments.

Therapeutically, they do *three* jobs: They provide mild counter-irritation which induces local and reflex hyperemia—helping to relieve congestion and muscle pain. They offer the anti-spasmodic medication of belladonna—which helps ease muscular cramps and pains. They aid immobilization—give a strapping and supporting effect which tends to reduce pain and irritation.

They are practical for you and for the patient. They are safe and convenient. They give continuous slow treatment for several days. They save you extra visits. The Johnson & Johnson name is accepted by patients.

Johnson's BACK PLASTERS are particularly valuable for low back strain, sacroiliac arthritis, myositis, lumbosacral fascitis and intercostal neuralgia.

* * *

Where the greater spasmolytic effect of belladonna is indicated, use the Johnson & Johnson BELLADONNA PLASTER with full U.S.P. belladonna strength.

Write for liberal free supply of Johnson's BACK PLASTERS and BELLADONNA PLASTERS. Both are helpful in many backache conditions. Johnson & Johnson, New Brunswick, N. J.

Johnson's BACK PLASTER

FORWARD STEPS IN SCIENCE

Copernicus laid the foundation for the advanced knowledge of astronomy. In like manner, Sklar's foresight in selecting the proper alloy of *American made* stainless steel for surgical instruments laid the foundation for the production of the most dependable instruments the surgeon has ever used.

During the past decade ceaseless research enabled American steel makers to win unquestioned leadership in the production of high grade stainless steel. Stainless Steel was a vastly greater factor in winning the war than is generally known.

It is a special alloy of this world's most perfect steel that is used for the making of Sklar Stainless Steel Surgical Instruments. That's why the surgeons always find in Sklar instruments strength, hardness, toughness, resilience and resistance to corrosion.

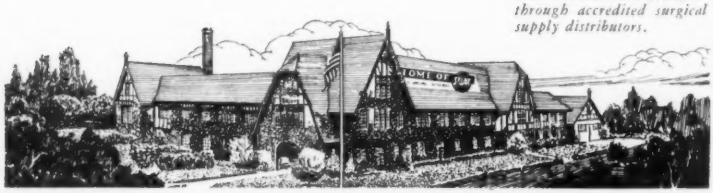
The J. SKLAR MFG. COMPANY makes the greatest variety of stainless steel surgical instruments ever produced by a single manufacturer.

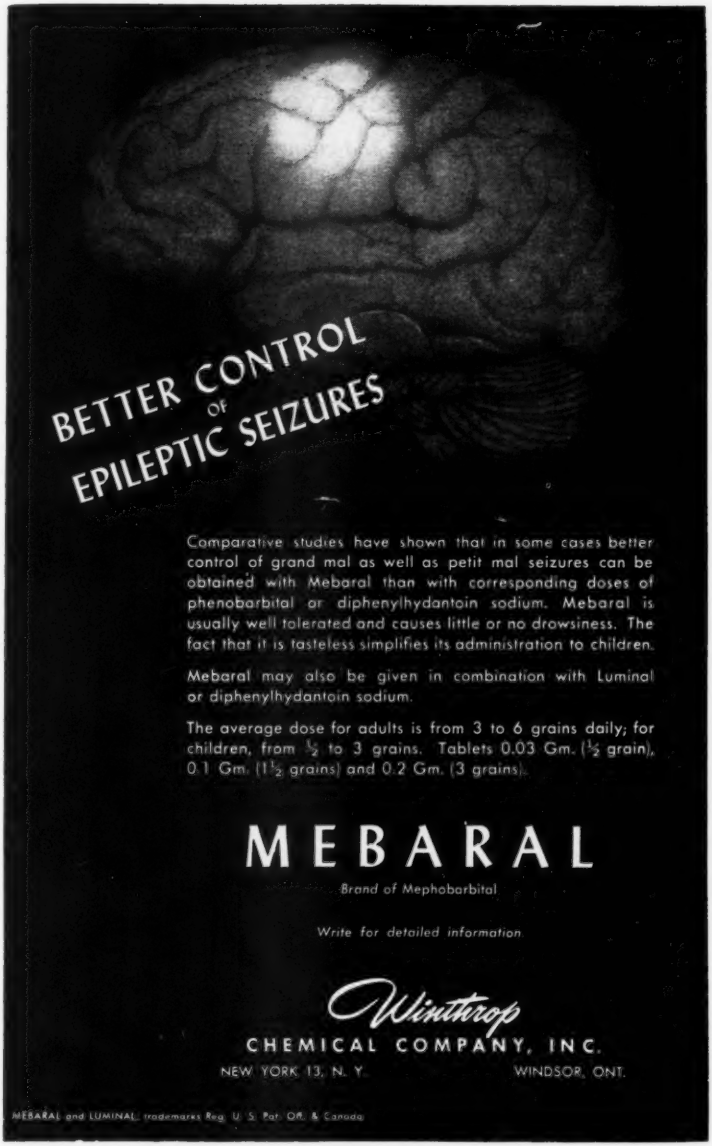
NICOLAUS COPERNICUS (1473-1543). Regarded as the founder of modern astronomy. Established the theory that the earth rotates daily on its axis . . . and that planets revolve in orbits around the sun.

Sklar

LONG ISLAND CITY, N.Y.

Sklar Products are available through accredited surgical supply distributors.




BETTER CONTROL
OF
EPILEPTIC SEIZURES
Comparative studies have shown that in some cases better control of grand mal as well as petit mal seizures can be obtained with Mebaral than with corresponding doses of phenobarbital or diphenylhydantoin sodium. Mebaral is usually well tolerated and causes little or no drowsiness. The fact that it is tasteless simplifies its administration to children.
Mebaral may also be given in combination with Luminal or diphenylhydantoin sodium.
The average dose for adults is from 3 to 6 grains daily; for children, from ½ to 3 grains. Tablets 0.03 Gm. (½ grain), 0.1 Gm. (1½ grains) and 0.2 Gm. (3 grains).
MEBARAL
Brand of Mephobarbital
Write for detailed information
Winthrop
CHEMICAL COMPANY, INC.
NEW YORK 13, N. Y.
WINDSOR, ONT.
MEBARAL and LUMINAL, trademarks Reg. U. S. Pat. Off. & Canada

Meet the Executive Secretary!

Seventy-three state and county societies now have full-time administrators

Organized medicine has enough generals who make plans at headquarters. It needs more shave-tails and sergeants to execute the commands. That's where a full time, salaried executive secretary pays off.

Medical society members can pass motions galore with no more effort than a full-throated "aye." But often it takes a full-time employe to put ideas on wheels and push them through to completion.

Although the office of executive secretary is an old one for most trade associations, it is only within the last twenty-five years that medical societies have begun to employ such administrators. Today more than forty county societies and thirty-three state societies are served by full-time executives. All the county executive secretaries are laymen, as also are twenty-nine of the state secretaries. No society is known to have ever abandoned the office after a reasonable trial.

Why are so many of these positions occupied by laymen? For one thing, few physicians are willing to give up medical practice for administrative work. Of those who do, few seem to be attracted to this particular field. Most physicians who seek executive careers find that hospital administration or industrial medicine offer more inviting terms of service and help them at the same time to keep up to date professionally.

The executive secretary's job is primarily one of public relations. A layman can often mingle more easily with lay persons and agencies than can a physician. Another point for the layman in medical society administration: It is obviously easier to maintain a clean-cut division between policy-forming and policy-executing functions if the executive officer is not a professional colleague of the members. Finally, while a society board might hesitate to discharge a fellow member in favor of a more promising candidate, it need not hesitate over an incompetent lay secretary. He can be kept on his mettle all the time.

Most full-time secretaries are in their middle or late forties; nearly all are college-trained. About half

---

▶ More and more medical associations are employing full-time executive secretaries, many of them laymen. Here, the executive secretary of a large county society points out what such an officer can do for any association with more than 200 members.

---

for Minimum Trauma in Hormone Injections

For minimum irritation and seepage from intramuscular hormone injections, thousands of physicians choose bright razor-sharp Vim needles. Vim points are hollow-ground with keen cutting edges that gently slit rather than puncture the tissues. Most important, physicians find that Vim needles hold their sharpness despite continued use and sterilization.

There are two excellent reasons why Vim stays sharp longer. Vim is the needle made from Firth-Brearley Stainless Cutlery Steel, the "sterling of stainless steels", which has been *heat-treated* and *uniformly tempered* to exactly the hardness demanded in a *cutting* instrument.

The following lengths and gauges for intramuscular work fit any standard luer syringe and may be ordered from your surgical instrument dealer:

20 gauge, in lengths 1″, 1¼″, 1½″, 2″, 4″
21 gauge, in lengths 1″, 1¼″, 1½″, 3″
22 gauge, in lengths 1″, 1¼″, 1½″, 2″

If you have been troubled with dull needle points, use Vim needles. They serve equally well for general Hypo, Intravenous, Intramuscular, Intradermal, and Subcutaneous work. Write us for a complete list of Vim sizes and points suited to your specialty.

MacGREGOR INSTRUMENT COMPANY - Needham 92, Mass.

FIRTH-BREARLEY STAINLESS

VIM
Trade Mark Reg. U. S. Pat. Off.

CUTLERY STEEL HYPO NEEDLES

Sold in

UNITED STATES: Surgical Instrument Dealers
GREAT BRITAIN: Henry Milward & Sons, Redditch, England.
SOUTH AMERICA: G-E Medical Products Co., Chicago, Ill.

CANADA: Ingram & Bell, Ltd.
Toronto, Montreal
Winnipeg, Calgary

came to this work from newspaper or public relations fields. Some have served their societies as long as fifteen years; a handful, twenty to twenty-five years.

A good executive secretary, M.D. or layman, must have two characteristics: (1) a real liking for doctors and a deep interest in their group problems, (2) an ability to coordinate diverse activities, to reconcile differing opinions, and to bring together contrasting personalities in a common cause.

The executive secretary has to keep a deft finger in every pie without putting his foot in any of them. He should know more facts, and express fewer opinions, on any nontechnical subject coming before his society than any of the members.

Other characteristics of a successful medical society administrator: a good memory for names and faces; a talent for clear, concise expression (via voice or pen); and a capacity for work.

The typical full-time secretary acts as executive officer of every committee, board, and agency of his society. He conducts routine correspondence, prepares press releases, drafts reports, assembles statistics, investigates complaints, maintains contact with outside agencies, and furnishes information about every conceivable subject of interest to any individual member. He manages, and frequently also edits, the society journal; oversees bookkeeping and budgetary operations; hires, fires, and supervises the rest of the society staff.

A major benefit of employing a full-time secretary is continuity. Elected officers come and go, but the paid secretary goes on. He helps succeeding boards to capitalize or improve upon the work of their predecessors. This makes for consistency of policy and growth of accomplishment.

The society with a competent, full-time administrator and staff usually has a high dues level. Salaries of county society secretaries are reported to range from $3,000 to $10,000; state secretaries, from $5,000 to $15,000. Many larger societies employ several full-time executives, lay or medical, for specialized functions. Administrative staffs may range from two to thirty or more workers.

Any medical society having more than 200 members would do well to install an executive secretary, either through its own funds alone or in cooperation with the local tuberculosis association, cancer society, or some other health or medical organization.

The society with a capable executive secretary is likely to have a program of progressive community service. This program can earn for it a recognized position of leadership. The flower of this entire process is the thing all medical societies yearn for: satisfactory relations with the public and a "good press" for the society.

A disease which has long taxed the physician's patience and therapeutic ingenuity now yields to treatment. No longer is there need to run the gamut of available medicaments for one that *might* prove effective.

RIASOL *is* effective in psoriasis. Proof of this is at once evident in the accompanying *unretouched before* and *after* photographs of an actual case treated with RIASOL. RIASOL rapidly clears the unsightly lesions, in many cases with minimal recurrence. Patient confidence and cooperation are assured.

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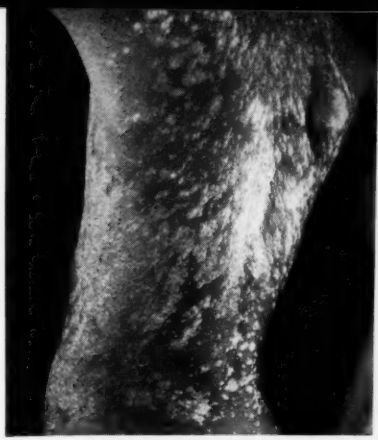
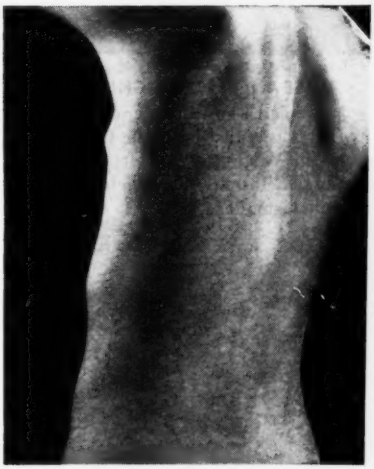


BEFORE USE OF RIASOL



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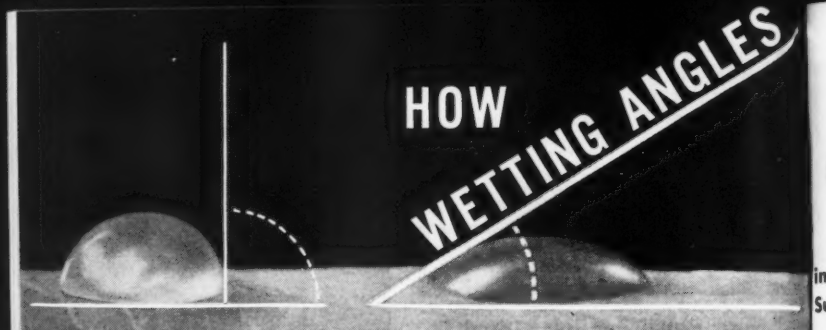
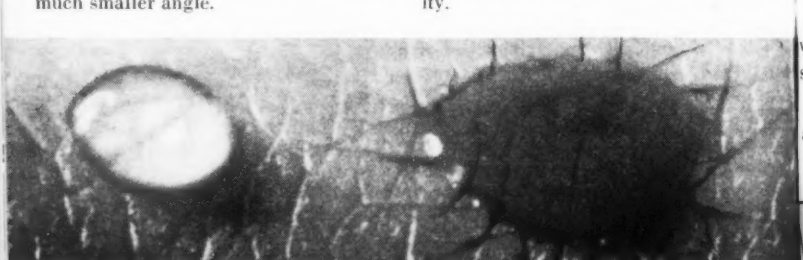
RIASOL FOR PSORIASIS



THESE ANGLES TELL SIGNIFICANT STORY. A vehicle's spreading and wetting capacity is revealed by angle of contact with skin. Water droplet (left) always has 90° angle. "Intraderm" vehicle (right) forms much smaller angle.

Droplets (both 0.02 ml.) photographed just after application to normal human skin.

Smaller wetting angle indicates greater wetting, spreading and contacting capacity.



TWO MINUTES LATER. Water droplet retains shape. "Intraderm" droplet has spread and seeped into furrows. Small wetting angle demonstrates efficiency of "Intraderm" vehicle.

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Each application takes only a few minutes.

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1. Penetrates normal and diseased follicles, enhancing general sulfide action.
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4. Softens and removes keratin plugs that block the follicles.
5. Effectively aids thorough cleansing of follicles.

Ingredients: Sulfur (as sulfides and polysulfides), 0.75%; triethanolamine, 10%; sodium mixed alkyl benzene sulfonate, 11%; antipyrine 11%; propylene glycol; water.

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Work of University and Industrial Researchers Said to Conflict

Present financial methods also said to hamper medical research

Medical researchers have to eat. More than that, they often have to hire assistants to help in their work. It all takes money. How they get it, and fear that they won't get it, has a lot to do with the kind of work they do and how hard they press to finish an investigation.

Most money to back medical research comes from private foundations and pharmaceutical houses. In 1941, latest year for which figures are available, thirty-three private research foundations had resources of more than $800 million. This year it is estimated that the pharmaceutical industry is putting 3 or 4 per cent of its $400 million income into research.

Two "basic weaknesses in medical research" were singled out recently by Dr. Charles W. McKhann, professor of pediatrics at Western Reserve University School of Medicine and director of pediatrics at Cleveland's University Hospitals. Doctor McKhann has been the recipient of research grants from both foundations and industry. He feels that

¶ The present system of financing medical research puts investigators on an insecure footing.

¶ Researchers employed by pharmaceutical companies are invading the domain of university researchers.

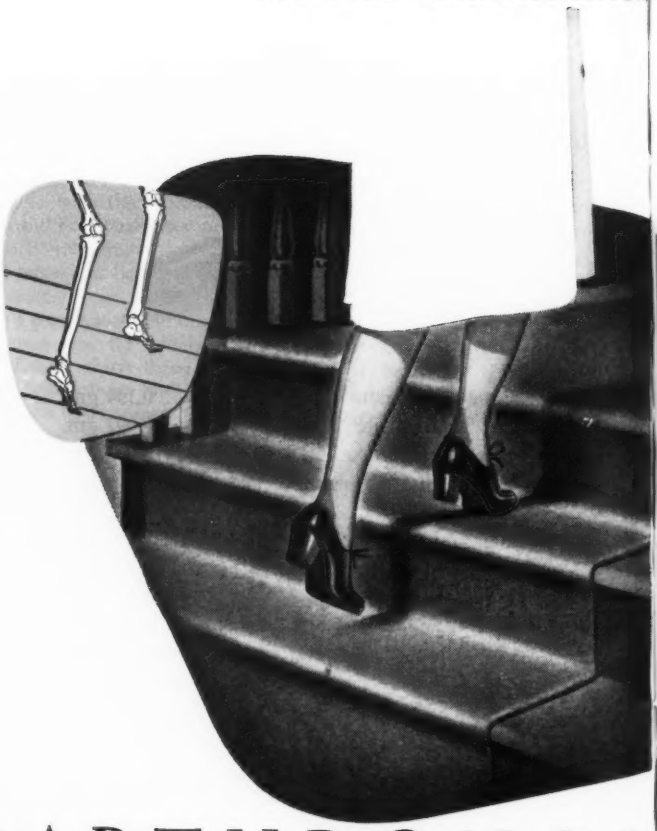
On the first point, Doctor McKhann argues that too many foundations and pharmaceutical houses extend research grants for projects alone. Their interest lies in a specific investigation, not in a man or in an organization.

Said he recently at a meeting of the American Pharmaceutical Manufacturers Association: "More and more one hears that medical research should be self-supporting, not dependent on grants from industry or from philanthropic organizations. Whether or not this is a desirable trend merits consideration.

"By the very nature of a grant-in-aid, it is impossible for an educational institution to build a strong, continuing investigative program. Support used to bring together a team of research workers is often lost when a project is completed or when the chief worker wants to change the direction of his investigation. The staff may be lost, too. The individual then has to begin over again, working alone, to develop a new program."

Doctor McKhann says he knows a few researchers who have hesitated to finish projects until others could be started. Other men, he

SYSTEMIC REHABILITATION FU



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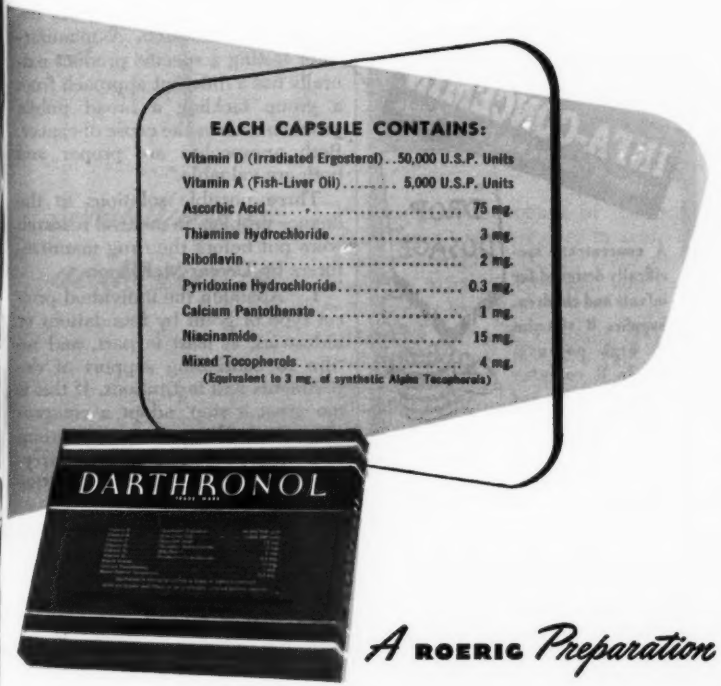

A **ROERIG** *Preparation*

says, look upon medical research only as a stepping-stone to more secure administrative posts.

He objects to the present way in which industry's research efforts are expanding. He favors support by industry for "fundamental research, for initiatory studies of new procedures, and for developmental work." But he adds: "Appraisal work must be unbiased. University research, in appraisal of products, must not be subservient to industry."

This warning that university research may become subservient to industry is a little too strong for Charles Wesley Dunn, APMA counsel. "It is impossible," he says, "to lay down such broad rules to define a certain sphere for each agency doing medical research. A manufacturer testing a specific product naturally has a different approach from a group tackling a broad public problem such as the cause of cancer. Both approaches are proper and both are valuable."

Three possible solutions to the finance problem in medical research were put before the drug manufacturers by Doctor McKhann:

1. "Abandon the individual project type of grant by foundations or industries, at least in part, and return to continuing support of departments and institutions. If this is too great a step, adopt a compromise: the backing of a man or group of men for so long as they are carrying on satisfactory investigative work."

2. "Permit medical research to obtain, accumulate, and control a share of the rewards arising from the outcome of such research, so that developments in one year will help the investigator support his own efforts in the following years.

secondary to acute coryza

"Practically all infections of the ears and nasal sinuses are secondary to acute coryza or nasopharyngitis. . . . The ideal procedure would be to use bactericidal and bacteriostatic agents locally. . . ."*

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*Dolowitz, D. A.; Loch, W. E.; Haines, H. L.; Ward, A. T., Jr., and Pickrell, K. L.: J.A.M.A. 123:534 (Oct. 30) 1943.

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In diaphragm-capped vials of 100,000 and 200,000 units.

OIL AND WAX

Squibb Crystalline Penicillin G Sodium in Oil and Wax has improved physical characteristics permitting easier administration . . . and provides prolonged-action penicillin in double-cell cartridges. One cell contains 300,000 units of penicillin in refined peanut oil with 4.8% bleached beeswax. The other cell contains sterile aspirating test solution to guard against accidental intravenous injection.

300,000 units in 1 cc. double-cell cartridge with B-D syringe, or for use with B-D* permanent syringe.*

Also in 10 cc. vials, 300,000 units per cc.

TABLETS

Squibb Tablets Crystalline Penicillin G Sodium (Buffered) are *individually* and *hermetically* sealed in aluminum foil to protect them from penicillin-destroying moisture. For high oral dosage.

100,000 units per tablet, boxes of 12 and 100.

All these dosage forms of Squibb Crystalline Penicillin G Sodium may be stored at room temperature. Refrigeration of aqueous solution is necessary.

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In other words, encourage medical research to become self-supporting."

3. "Gradually see the role of medical research in educational institutions diminish and productive research become housed in institutes maintained by the manufacturers of pharmaceutical and biological products."

Speaking against the last possibility, the doctor said, "I am not at all sure it would be in the best interests of industry to weaken the training grounds for research personnel in our universities. If industry is to have available a strong, well-trained group of men, there must be places for these men to be trained. Many types of research are better carried out in universities. The initial investigation, the pioneering, and the prospecting done by thousands of men in universities cannot profitably be carried on in the circumscribed industrial laboratories, regardless almost of the number of personnel available."

This fear of industrial domination is groundless, according to Mr. Dunn. "Basic medical research," he says, "has always been the role of university laboratories, and it always will be. Manufacturers are concerned mainly with applied research. But it would be wrong to exclude them from the field of fundamental research since their laboratories have made valuable contributions. Research must work out its own levels on a practical basis."

Some universities have long been making their laboratories pay their own way by patenting the results of their research. But according to Dr. Alan Gregg, of the Rockefeller Foundation, there are dangers in this practice also. In his book, "The Furtherance of Medical Research,"

he concedes that one advantage of the system is revenue for the university; but he adds a further thought: "Patent litigation will steal time and money that could be expended on research. The suspicion of secret gain will create jealousy and invite secrecy among scientists and schools. A premium may be placed on appointing men whose chief talent is for patentable discoveries."

What, then, is the future of university research? Pointing to the policy of industry and foundations to support medical research by grants-in-aid, Doctor McKhann says, "We see Government entering the field of research or proposing to enter it on a very large scale Apparently grants-in-aid will be used. Whichever group recognizes first the shortcomings of the grants-in-aid system may grasp the leadership in research away from the other groups."

—ALLEN ELY

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice. Contributors may remain anonymous upon request.

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NEW INFANT SKIN CARE TECHNIQUE CAUSES SHARP DROP IN MILIARIA

Johnson's Baby Lotion leaves a discontinuous film. 1000x.

FOR THE PAST four years, a new preparation for infant skin care has been making a dramatic record in test hospitals.

This preparation is Johnson's Baby Lotion—a smooth, white, antiseptic Lotion for routine inunction.

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Johnson's Baby Lotion, a homogenized emulsion of mineral oil and water with lanolin added, leaves a *discontinuous film* on the infant's skin.

As the water phase evaporates, a protective network of micron-size oil globules remains. This permits normal heat radiation, and allows perspiration to escape readily—thus lessening the danger of miliaria.

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Offer limited to medical profession in U.S.A.

Writing for Medical Journals

If you want to catch readers, put a hook in your first sentence

There are eight ways to open a medical paper. The right lead sentence gets a reader interested; the rest of the opening paragraph tells him what's coming. But, as the following examples show, it takes plenty of thought to get off to a good start.

Consider eight types of openings and select the one suited to your paper. These are: (1) historical, (2) statistical, (3) definitive, (4) expository, (5) anecdotal, (6) dramatic, (7) philosophical, and (8) apologetic.

Historical. Many authors start with a review of the subject's history. This is usually pretentious and often inappropriate. If you are presenting a technique for the treatment of sinusitis or the diagnosis of cirrhosis, the views of Hippocrates and Galen have no practical value to today's reader. Tracing the history of the disease from antiquity to atom bombs is mere ornament.

Historical openings are justified in articles offered as historical rather than clinical presentations and, sometimes, when a review of the historical background is indispensable in understanding modern concepts. An exception might be the report of an exquisitely rare condition, in which the historical record (or lack of one) is the justification for the article.

For instance:

> "It is now more than thirteen years since Brown's original report of arteritis induseus griseus. In that interval only four other cases have been recorded. It is therefore of interest to present a confirmed case of that rare disorder, the fifth on record."

On the other hand, a paper explaining how to treat rickets should not open thus:

> "Although the name of Glisson is associated with the earliest description of rickets, many others preceded him. Indeed, as far back as 1645, Whistler described the condition, and in 1890 cod liver oil was first used on an empirical basis."

This airs the writer's erudition, but serves no other purpose. The practitioner who wants to know how to treat rickets will either skip that

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▶ Henry A. Davidson, M.D., editor of The Journal of The Medical Society of New Jersey, has prepared a series of articles on how to write for professional journals. This is the third; the first appeared in January.

paragraph or turn to the next article.

Statistical. The writer can make a dull set of figures leap into life by selecting some dramatic fact as a springboard. Here, for example, is the unimaginative opening sentence of the first draft of a paper:

> "The importance of diseases of the joints can be best understood by an analysis of the figures of the Public Health Service, which indicates, on the basis of nationwide extension of available samples, that in the United States there are 6,800,000 cases of joint diseases on any one day, and since 5 per cent of these represent working disability, a weekly loss from work of the productivity of more than 2,000,000 men."

The lead was rewritten by extracting the dramatic fact that 2 million workers were disabled weekly and using this as the opening sentence, thus:

> "A hundred million work days are lost every year because of arthritis. Few other diseases take so great an economic toll . . ."

If a statistical opening is necessary, this kind of treatment will shape the lead paragraph into a hook for the reader's interest.

Definitive. Some medical writers labor under the scholastic delusion that every treatise must begin with a definition. Only this can account for an opening such as:

> "A fracture is a more or less complete solution in the continuity of a bone."

Openings of this type are turgid and patronizing. A definitive opening is justified only when the syndrome is obscure. Thus, in a general practitioner's journal, the following would be an adequate lead paragraph:

> "Rhinoscleroma is an uncommon, chronic disease of the nose and pharynx characterized by a crust-covered scar on . . ."

The same opening would be out of place in a specialized journal for laryngologists. If a definitive opening is necessary, it should be written with painstaking simplicity. Otherwise the definition may sound more obscure than the defined word itself. Thus:

> "Migraine may be defined as an idiopathic, unilateral, paroxysmal hemicrania of doubtfully familial pattern, with constant ocular and gastro-intestinal concomitants."

In this case it was presumptuous of the author—remember, he was writing for other doctors—to define migraine at all. If a definition were necessary, the paragraph quoted certainly would not serve the purpose. It should have been written in unadorned English:

> "Migraine is a one-sided headache of unknown cause associated with nausea and blurred vision."

Expository: The commonest, simplest, and sometimes the best lead usually gives the factual background. But this may be yawn-inducing unless the author takes the trouble to rework it until it shows vigor. Consider this expository opening:

"A study of the effects of penicil-

lin on neurosyphilis was begun at the Hillside Hospital on Oct. 15, 1944. This paper deals with results of the first two years of that study. As of Oct. 15, 1946, we had treated sixty-three patients . . . "

While there is nothing really objectionable about this opening paragraph, it lacks reader appeal. A more attractive lead would be:

"Patients with neurosyphilis often respond well to penicillin. This conclusion is based on a study of sixty-three patients in two years at . . . "

Note that the revised opening paragraph compresses the conclusion of the article into one sentence. It tells the doctor that if he will read on he will learn a new and useful method of treating a common and stubborn disease.

An expository opening may sometimes consist of a question to which the author offers an answer, thus:

"On what factors does success in ethmoid surgery depend? An analysis of 114 operations with careful follow-up study reveals that . . . "

Anecdotal: A paper read at a medical meeting may begin with a story of a patient or with an account of an event of the day, provided that you are a good raconteur. In cold type, however, such an opening may appear strained. If there is an interesting story behind the report, it may be used as a lead, but it should be done simply, thus:

"As a result of the Winecoff Hotel fire in Atlanta in December 1946, the staff of the X hospital treated 250 cases of burns and was able to compare the tannic acid, sulfadiazine, and picric acid methods of treatment . . . "

This is a simple, sober statement of fact, using an event as a lead. If the author had attempted to overdramatize it, he might have produced some such miscarriage as:

"On an unseasonably warm December evening, the shrill cry of 'Fire' sent thousands of spectators pouring onto the pavement of Atlanta's famed Peachtree Street . . . "

The anecdotal opening may be used in single case histories if the author comes to the point quickly. Thus, an account of a case of acute lead colic might begin:

"Last March, a 35-year-old worker in a paint factory, in a hurry to finish lunch, ate his sandwiches without the usual preliminary hand-washing. That evening he lay on the floor of his home, writhing in abdominal pain . . . "

On the other hand, the author should not begin too far back in the hope of giving himself a running start. It would certainly have been

to combat

depression characterized by

"chronic fatigue"

Depressed patients "... suffering from psychomotor inhibition complain of feeling tired, of not being able to get started on their daily tasks, and of an abnormal inclination to procrastinate. They make up their minds that they are going to do a certain thing but they never seem to get to it. Everything seems too big for them..."*

In the above quotation, Kamman emphasizes "chronic fatigue" as a dominant symptom in the type of depression most frequently encountered in daily practice.

Benzedrine Sulfate is particularly valuable in the presence of "chronic fatigue". It will, in most cases, help to overcome the depression and thus enable the patient to make a sincere and constructive effort to surmount his difficulties.

*Kamman, G. R.: Fatigue as a Symptom in Depressed Patients, Journal-Lancet 65:238 (July) 1945.

b

Tablets and Elixir

benzedrine sulfate

(racemic amphetamine sulfate, S.K.F.)

Smith, Kline & French Laboratories, *Philadelphia, Pa.*

bad judgment to have opened that paper with:

> "Every paint factory is plastered with signs: 'Wash your hands before you eat!' Most workers understand that warning and observe it. However, on March 4, 1946, a 35-year-old paint sprayer, in a hurry to go to his bank during his short lunch period, ignored the warning, unwrapped his sandwiches and . . . "

Dramatic. The most effective of all openings is the dramatic one that isolates some startling fact and uses it to catch the reader's eye. Thus an article on emotional factors in suicide began this way:

> "During the twenty minutes it takes you to read this article, someone, somewhere in this country is going to kill himself. That is the suicide rate in the United States: seventy-two a day, three an hour, one every twenty minutes."

The unrevised version of the same paper began with the statement that

> "There are approximately 25,000 successful suicides in the United States annually."

Almost any expository opening can be made dramatic if the author picks out the most arresting observation in his paper and uses it in the first paragraph. An article on malaria originally began with a solemn remark about epidemiology and then took several paragraphs to tell the doctor what he knew anyway, about the plasmodia and the anopheles. The revised paper began:

> "Norfolk is a long way from New Guinea, but we can expect thousands of cases of malaria here this year . . . "

A paper on diabetes in children might start with a definition, an exposition of the writer's research project, or with a set of figures. A better way would be this:

> "Once a death sentence for children, juvenile diabetes is now a disease that can be, and should be, controlled . . . "

So many papers pour off the presses each month that the medical author, no matter how important his message, cannot expect full attention unless he has some technique for arousing reader interest. A dramatic opening is one way to do it.

Philosophical. Medical articles before World War I were usually written in elegant style, replete with classical citations and philosophical observations. This style has gone with the horse and buggy, though it occasionally (and properly, perhaps) reappears in Presidential addresses and in college commencement speeches. Editorials and articles of comment may use a philosophical opening effectively if the more dynamic style forms of modern English are retained. In a scientific article, the philosophical opening has no place. Here are some examples:

From a paper urging that treatment techniques be highly individualized to meet each patient's needs:

> "In a world that is going in more and more for mass production, in a country in which government paternalism of people in groups

For "the most common type of anemia encountered in the aged"

Stieglitz,* who found iron-deficiency anemia in approximately 70% of a group of patients over fifty years of age, stresses that "One must depend on iron medication and as near a normal diet as the patient can eat."

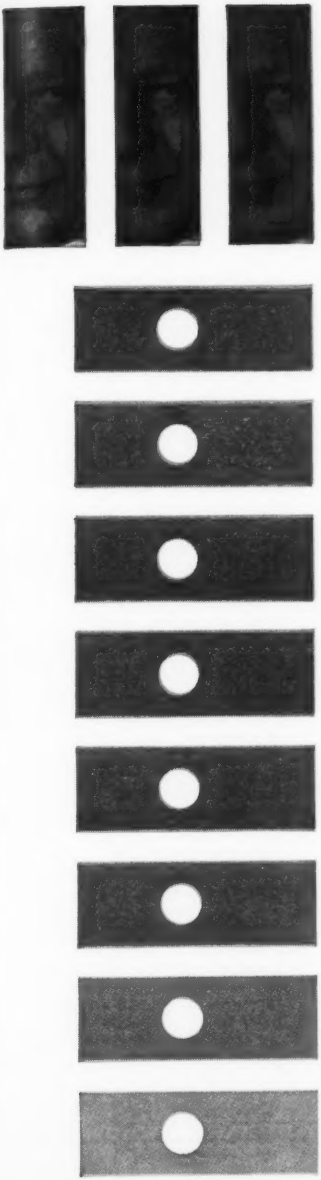
Feosol Tablets and Feosol Elixir provide adequate dosage of ferrous sulfate—grain for grain, the most effective form of iron therapy. They achieve the essential objectives of iron therapy: rapid hemoglobin regeneration and prompt reticulocyte response.

*Stieglitz, E. J.: Geriatric Medicine, Phila., Saunders, 1943, pp. 209, 825, 826.

Feosol Tablets *and* Feosol Elixir

The standard forms of iron therapy

Smith, Kline & French Laboratories, *Philadelphia, Pa.*



For simple hemoglobin determinations in preliminary diagnosis, the Feasol Hemoglobin Scale is invaluable. The latest edition will be sent you promptly on your request. Smith, Kline & French Laboratories, 429 Arch St., Philadelphia 5, Pa.

seems to be the rule, in an age when games, radio, movies, and books are all coming in on a belt line, it may appear old-fashioned to urge that we doctors stop a moment and think of the individual. Yet the cure of bodies is our sworn duty and the dignity of individuals is our solemn charge . . . "

From a paper on the management of pregnancy:

"The do-nothing attitude of many obstetricians is but the relic of the primitive feeling that childbirth is the punishment for carnal sin. So it was defined in *Genesis* III:16. And while leaders have blazed the path for progress in obstetrics, too many, even in the medical profession, have been loath to follow . . . "

From a paper on constipation:

"Man is what he eats, says an old German philosopher. And in that there is much truth. Modern man, surfeited with meats and pastries, contemptuous of vegetables, clamoring for pre-cooked, pre-digested, pre-heated foods, gobbling meals hastily at a counter, is . . . "

The only treatment for the philosophical opening is to take a blue pencil and draw a line firmly through it.

Apologetic. The apologetic opening is the sign of the amateur:

"There is no need to tell an audience of this distinction that . . . "

"It is with considerable trepidation that I address you . . . "

If an apology is necessary, the article isn't.

In modern medical journalism, a scientific article starts promptly and vigorously. The experienced author omits all philosophical musings, historical summaries, and apologetic announcements. He starts with his conclusion, compressed into a single sentence; or with an interesting, dramatic, or useful item selected from his text and brought to the first paragraph to arrest the reader's attention. Definitions are used only if the subject is obscure and are written with careful simplicity. Statistical items are not used in opening paragraphs unless they can be presented dramatically. Humorous openings are not considered good taste in medical articles. A helpful observation or a practical treatment tip makes an excellent opening.

—HENRY A. DAVIDSON, M.D.

EFFECTIVE RELIEF FOR THE INDISCREET

Excessive eating, drinking or smoking often makes disquieting nausea and stomach upset part and parcel of the proverbial "morning after."

When such distress is the result of gastric hyperacidity, you'll find BiSoDoL a well qualified counter-measure. It provides soothing, effective relief quickly—and maintains it for a gratifying period of time.

BiSoDoL's widespread medical acceptance plus its long-established reputation for outstanding results assure you of a product worthy of your consideration.

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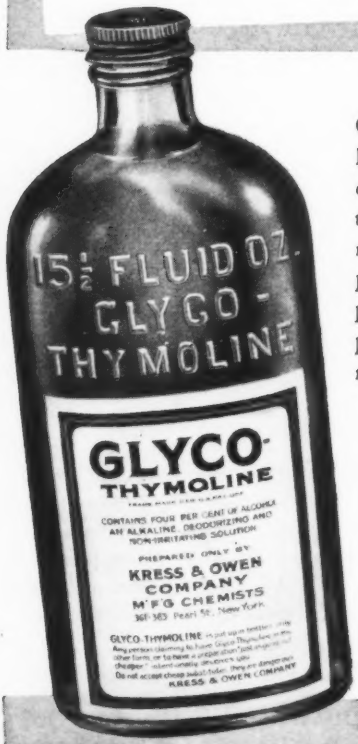

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Working on the Railroad

Facts on the work of a railway surgeon, and what the field offers

During my childhood there was one career that appealed to almost every boy, and that was railroading. Though aviators and G-men have since largely taken over youthful ambitions, the urge to be associated with this country's mighty transportation system remains. I never achieved my own desire to drive a locomotive, but I did become associated with the railroads as a railway surgeon.

When I started, more than thirty-five years ago, the chief function of a railway doctor was to care for injuries. Accidents were occurring all the time. The M.D. had to be on the job constantly, often displaying considerable ingenuity in adapting his meager equipment to serious surgical problems.

Today the work is less exciting but equally exacting. Medical and hygienic service far overshadows that of a traumatic nature.

Prevention is now the keynote of the railroad physician's duties. Safety devices have multiplied steadily. Some lines have run for years without serious accident.

But it is still the man and his well-being that count. A tiny hemorrhage in the brain can nullify the most elaborate safety devices.

An example of the preventive aspect of the railroad doctor's work is the care he must take of dining-car personnel. A railroad diner is one of the safest places in the world to eat. Cooks and waiters are examined scrupulously. They are required to scrub their hands with tincture of green soap after relieving themselves. No employe is permitted to work if suffering from syphilis, gonorrhea, or tuberculosis. Few restaurants and hotels are as careful about this.

A large part of the railroad physician's work now consists of periodic health examinations. The doctor in this field must therefore be a good internist and a keen diagnostician.

Training in general industrial surgery is valuable; but the foundation is obtained outside railroad circles—in approved medical schools, in good interneships and residencies, and in postgraduate work. Practical experience under an older railroad surgeon is advisable, too.

Opportunities for obtaining railroad positions vary. There are more than 100 Class A railroads employ-

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▶ Don Deal, M.D., author of this article, is a past president of the American Association of Railway Surgeons.

ing well over a million men. Most of these roads have a chief surgeon plus local district and division assistants. Vacancies occur frequently. In small towns where there are few physicians, opportunity for appointment is greater than in cities where there may be several hundred doctors and relatively fewer railroad positions to fill.

To obtain a position as railway physician, application must be made to the chief surgeon of the road. Medical qualifications, credentials, and letters of recommendation should be included in the letter.

The hours of a railroad doctor depend on his agreement with the company, but he must always be available in the event of emergency. In concentrated areas, he may have regular office hours; in some districts, on a fee basis, he may be called at any time.

Work is full time or part time, depending on the place. Most surgeons can have some private practice; many, because of the recognition their position implies, develop a sizable consultative practice.

Except in the case of full-time men, virtually no travel is required, but this, too, varies with local conditions and emergencies. Rent, equipment, meals, and other expenses are rarely paid for. Two to four weeks' vacation with pay is the rule.

Most railroad physicians, especially those on part time, use their own offices. Many companies provide first-aid stations; some of the larger ones have their own hospitals. Sometimes all cases from a company are sent to a particular hospital in a city where the railroad maintains its own ward. Generally, nursing service is provided at com-

pany expense, especially in hospitals. Railroad patients' prescriptions are filled by local drug stores.

Compensation varies. For full time it may start low; but among chief surgeons it often amounts to $15,000 or more. Some railroads pay salaries, but most pay on a fee basis. And there are non-monetary compensations also. A pass giving free transportation over the company's lines is frequently furnished.

Railroad work tends to be permanent. The average length of service may be estimated at twenty-five years, but there is no real limit.

Opportunities for the advancement of those holding full-time positions occur as vacancies higher up arise. The holder of a minor position may climb to be chief medical officer or chief surgeon. On the other hand, for those who are on a fee basis, there is little chance for advancement. One good technique is to attain prominence in a particular line of work; advancement will then tend to be more rapid.

We in this field have an organization of our own: the Association of Railway Surgeons. It is composed of separate system associations whose purpose is to exchange new ideas and experiences, much like any progressive medical organization. Dues are nominal and include a subscription to the magazine Industrial Medicine.

I see many advantages to being a railroad physician. The position is usually permanent and many lines include some arrangement for pension after retirement. Bills are always paid, and paid promptly. Railroad employes are a class by themselves, often more satisfactory to treat than the average patients in private practice. —DON DEAL, M.D.

Medicine's Role in Crime Detection

A physician-detective cites his experience in the field of scientific sleuthing

The detective of a generation ago was often described as a tall, angular individual who spent most of his time lurking in shadows. He could make extraordinary deductions by viewing commonplace objects. Today's super-sleuth is likely to be a scientist—perhaps even an M.D.

In recent years, there has developed a vast field of scientific crime detection. Doctors have contributed much to modern methods. Even modern techniques of firearms identification stem largely from the work of a prominent American physician, Dr. Calvin Goddard. Let's examine a few crime-detection branches to which medicine and allied sciences have contributed.

DID HE DROWN?

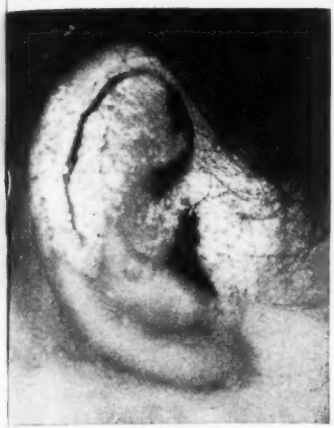
Suppose a man disappears and two or three days later his body is found in a river. The police want to know whether he died by drowning. It used to be difficult to tell because there was no single pathognomonic sign of death by drowning. But now the blood choride test, introduced some years ago by Dr. Alexander O. Gettler of New York, makes it possible to decide accurately. If a person dies by drowning, water will rapidly make its way, before death, from the lungs into the circulation to the left ventricle, thereby diluting the blood in that chamber. Consequently, when the chloride content of the blood in the left ventricle is compared with that in the right, it is possible to determine any dilution, if present.

"TRUTH SERUM"

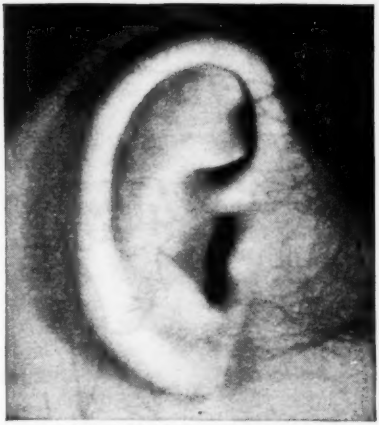
In no phase of scientific crime detection has so spectacular an advance been made as in the field of proving deception. Several years ago a southern physician suggested the use of scopolamine in the examination of suspects. This was seized upon by the press and headlined as "truth serum."

One of the most pronounced effects of this derivative of the atropine group is amnesia for recent events. A criminal often constructs an elaborate alibi, but the crime itself is deeply impressed in his intellect. When scopolamine is administered, the alibi cannot be re-

▶ Le Moyne Snyder, M.D., author of this article is the medicolegal director of the Michigan State Police. Recently he joined forces with a handwriting expert, a detective, a physicist, and a lie-detector specialist to form an agency that specializes in scientific investigation.



PSORIASIS—Duration 25 years



After 20 days treatment

Simple, Effective Dermal Therapy

Doctor, for those seemingly unending cases of stubborn skin conditions that do not respond to ordinary treatment methods, may we suggest your trial of Mazon Soap and Ointment therapy?

1. **Cleanse affected area with Mazon Soap.**
2. **Rinse thoroughly and dry.**
3. **Apply Mazon Ointment.**

INDICATIONS

Indications for the Mazon Treatment are as follows: Eczema, Psoriasis, Alopecia, Ringworm, Dandruff, Athlete's Foot and other skin irritations not caused by or associated with systemic or metabolic disease.

MAZON SOAP

Mazon Soap is 100% pure, contains no free alkali, artificial color, synthetic perfume, excess oils or greases to retard or nullify the therapeutic action of its complement, Mazon Ointment.

MAZON OINTMENT

Mazon Ointment itself is absolutely anti-pruritic, anti-septic and anti-parasitic. It is easy to apply, is non-greasy and non-staining and requires no bandaging.

The amazing record of success in the many clinical studies suggests your own trial of the Mazon Treatment.

OINTMENT MAZON **SKIN SOAP**

FOR EFFECTIVE DERMAL THERAPY

BELMONT LABORATORIES CO., PHILADELPHIA, PA.

Physicians the world over rely on this easily tolerated, outstandingly palatable tonic to restore appetite, vigor and general tone . . .

Eskay's Neuro Phosphates . . .

clinically proved and universally accepted

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called but the details of the actual crime are.

The person to be questioned first receives a hypodermic injection of 1/100 grain of scopolamine. At intervals of twenty minutes he receives injections of 1/200 grain for four to six more doses. By that time he is in a state of mild delirium. It is difficult to hold his attention on the subject at hand. The questions must be short. If a long, involved sentence is used, the suspect will forget the first part of it by the time the query is finished. The questions must be repeated time and again, as the depression apparently travels with wave-like rhythm. When at the top of the wave, a person will answer readily, and when at the bottom, will say nothing. Of the other hypnotics that have been tried, sodium pentothal has proven best.

LIE DETECTORS

Scopolamine is valuable in selected cases, but the dosage is so high that some doctors hesitate to use it. A procedure of far greater usefulness involves the polygraph, or so-called "lie detector." The Keeler polygraph is a combination of a recording sphygmomanometer and a pneumograph. On a moving slip of paper it indicates both respiratory excursions, fluctuations in blood pressure, and variations in resistance to electrical current passing through the head.

It has long been known that persons consciously lying are often betrayed by blushing, sweating, throat dryness, frequent swallowing, and other phenomena. The ancient procedure of trial by ordeal usually depended on one or more of these disturbances, such as the inability to swallow a mouthful of flour because of lack of saliva.

A person tested for the first time on the polygraph is usually quite nervous. Accordingly, the machine is allowed to operate for a minute or two before any questions are asked. The graph will usually smooth out in that time.

At first simple questions are asked: "Have you had breakfast this morning?" "Do you smoke?" "Do you drive a car?" These are intended to accustom the subject to the apparatus, and to see what response is recorded. Then questions about the crime that can be answered by a simple "yes" or "no" are asked. These are interspersed with simple questions, like those at the beginning, to throw the answers to the central subject into the greatest possible relief.

The polygraph has proved of particular value in examining persons against whom there is no evidence. For instance, money may be missing from a bank. Any one of many persons in the bank may have embezzled it, but there is no evidence against one individual. The entire personnel may have to be examined by the polygraph.

The results are amazing. In recent years, approximately 2,000

bank employes in fifty-two Chicago banks have been examined by this instrument in an effort to detect embezzlers. In many of the banks, 10 to 25 per cent of the personnel were found to be lying about the theft of money belonging to the institution; almost all these records were corroborated by admissions.

In one instance a bank wished to detect the embezzlers of $5,000. Tests of all fifty-six employes were made. Not only was the guilty individual discovered but eleven others were found to be lying about other thefts. Of this number, nine confessed to embezzlements that had never come to light.

A number of banks will not employ a job applicant until he is tested on the lie detector and questioned about previous employment. In many instances it is found that the applicant has embezzled. Generally he will admit it readily but will be recommended for a position, as no employe is so safe for a bank as one who has been caught on the polygraph.

The polygraph not only detects the guilty, it also protects the innocent. In several instances in my knowledge, an innocent person would almost certainly have been convicted had not the polygraph indicated his innocence and later events corroborated its accuracy.

WAS IT MURDER?

The dermal nitrate test is one of the important criminological developments of recent years. By means of it, it is possible to tell with high accuracy whether a person's hand has recently fired a gun. When a revolver is fired, particles of unburned powder are driven backward into the skin of the hand that holds the gun. These particles come from the pressure zone that develops around the muzzle at the time of discharge, and also from a flashback around the breech. They do not settle lightly on the surface of the skin, but are driven deep into the cortex.

To perform the test, melted paraffin is allowed to drip to the back of the hand and to solidify, forming a cast of the entire dorsal surface. After the paraffin has been allowed to cool, it is gently peeled off in one piece. A reagent is then applied, drop by drop, to the paraffin. If it strikes even a microscopic particle of unburned powder, a dark purple spot will stand out plainly against the white paraffin.

Ordinary washing of the hands will not remove these particles of nitrate embedded in the skin. I have been able to obtain positive tests as long as seventy-two hours after the gun has been fired. The dermal nitrate test is particularly effective in deciding whether a person who died of bullet wounds was murdered or was a suicide.

WHICH GUN DID IT?

When Jake Lingle was slain in Chicago some years ago, the murderer took the precaution to file off


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MUSCULAR ACHES
AND PAINS . . .
Suggest
ABSORBINE JR.

ANSWERS TO PRONUNCIATION QUIZ

(*See page* 75)

1–B; 2–B; 3–A; 4–B; 5–A; 6–A; 7–A; 8–B; 9–B; 10–A; 11–A; 12–B; 13–A; 14–A; 15–B; 16–A; 17–A; 18–A; 19–A; 20–B; 21–B; 22–B; 23–B; 24–B; 25–A.

all serial numbers on the revolver used. However, within a few minutes after this gun was taken to the crime detection laboratory, the numbers were restored and the gun was identified. The murderer was apprehended.

When a serial number is stamped into the steel of a gun, the crystalline structure beneath the numbers is compressed for a considerable depth. Should the number be cut off with a grindstone or file, the disturbance in the steel structure remains. When this is heated and a strong acid applied, the undisturbed part of the metal is dissolved normally and that which was compressed is etched out slowly. In a few moments the number begins to reappear as the acid continues to do its work more rapidly on the uncompressed steel.

There are many other ways in which the medical profession has made important contributions to crime detection. For example, the use of blood-grouping examinations in paternity cases was an important advance. But there are still many ways for medicine to make other contributions. A physician who pursues scientific crime detection as a sideline will not only find himself fascinated by the work, he will also contribute to the welfare of society.

—LE MOYNE SNYDER, M.D.

Positions Wanted by Physician-Veterans

APPROVED RESIDENCY; now P.G. student in obstetrics and gynecology; available May or June 1947; age 35; now in Pa. Box 1768.

ASSISTANTSHIP with American board surgeon; 12 months' interneship; 29 months' surgery overseas; age 31; Mich. license; now in Ala. Box 1766.

ASSISTANTSHIP to general surgeon; prefer diplomate American board; 15 years' hospital experience; 3 years' resident surgery; Mich., Ind., Iowa licenses; now in Neb. Box 1767.

GENERAL PRACTICE; part-time, evenings and week-ends; now taking 1-year P.G. radiology course; now in N.Y. Box 1760.

GENERAL PRACTICE in community up to 5,000; New England or Middle Atlantic states preferred; age 28; now in N.Y. Box 1769.

INDUSTRIAL appointment with coal mining company; age 33; 10 years' general practice; now in N.Y. Box 1762.

INDUSTRIAL or insurance connection in Chicago area; age 40; extensive training in general medicine and psychiatry; have fully equipped office; now in Ill. Box 1763.

INDUSTRIAL or pharmaceutical position; part-time basis; industrial and writing experience; age 35; Calif. license; prefer Los Angeles; now in Calif. Box 1758.

INDUSTRIAL, insurance, or pharmaceutical position; Boston area preferred; 4 years' general practice prior to service; instructor in pharmacology; now in Wash., D.C. Box 1765.

PSYCHIATRIST; full- or part-time position; 10 years' general practice; graduate School of Military Neuropsychiatry; N.Y., N.J., Conn. licenses; now in N.Y. Box 1761.

PSYCHIATRIST; position with group, industry, or mental health clinic; certified; age 34; licensed N.Y., Ill., Mo.; Calif. license pending; now in Ill. Box 1764.

UROLOGY assistantship or training; prefer Calif. or Col.; age 26; 19 months' Army; Col. license; now in Col. Box 1759.

Tax Consultant Views Questions That Often Stump Physicians

Eight of the most controversial issues raised by your income tax return

Can non-medical membership dues be deducted? The answer is yes if you joined a club or association purely for business purposes. Revenue Hawkshaws often scrutinize such deductions, but if you can prove your membership was intended and used strictly for professional reasons, the chances are that your claim will be allowed.

Are deductions allowed for entertainment costs? If they are within reason and can be substantiated —yes. Add up the myriad lunches you've paid for, the little presents you've sent, the bar tabs you've picked up, and the total for 365 days will probably stagger you. Yet money spent entertaining colleagues and business associates is considered a legitimate business expense. If the amount deducted is nominal, you may not be asked to validate it. If the amount, in relation to your income, is high, proof may very likely be demanded. In any event, an accurate record of entertainment expenses is highly desirable.

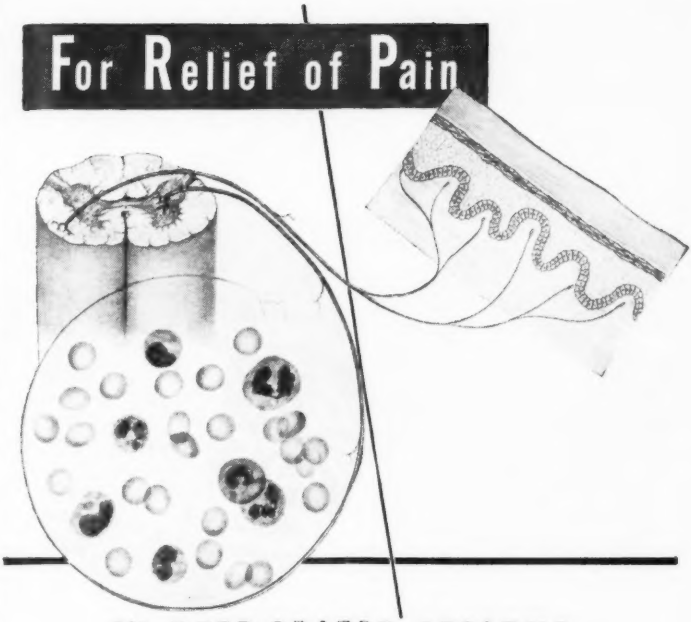
Can a doctor deduct the cost of buying and laundering uniforms? According to the letter of the law, no. If the point were contested, though, such a deduction might be allowed. Nurses got their backs up about this in 1945, with the result that the Collector of Internal Revenue finally conceded that nurses' uniforms were a business expense. Baseball players have been deducting the cost of their flannels since 1938. Right now, without a contest, a deduction for a doctor's uniform would probably be disallowed.

Must taxes be paid on obsolete equipment? It depends. There is a prescribed allowance for depreciation; but suppose your $1,500 X-ray machine becomes out-dated? Must you keep on paying taxes on it until its value depreciates to zero? Not necessarily. The best thing, however, is to get rid of it.

If you abandon an obsolete item, you can claim its current worth as a deduction. But you must actually part company with it. One method is to reduce it to junk. A better plan is to sell it. Then you may deduct as a loss the difference between the sale price and the machine's current worth. The bill of sale will provide all the evidence required.

Another way to save taxes on an expensive white elephant is to donate it to a charitable or educational institution. Then you can claim the fair market value of your

For Relief of Pain



IN DEEP-SEATED LESIONS

Inflammation in deep-seated tissue may be relieved by counterirritation of the skin. Pain and possibly congestion are diminished and an earlier and more conservative termination may result.

MINIT-RUB is the *modern* counterirritant for such analgesic and decongestant action. Direct rubefaction improves local circulation and aids in speeding relief to affected areas. MINIT-RUB may be recommended with confidence for supplementary home use when counterirritation is indicated. It is very useful in relieving the distressing sequelae of coryza.

STAINLESS • GREASELESS • VANISHING

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gift as a contribution deduction. Perhaps the item is of little value to you, but it may be worth much to a hospital or clinic. To be safe, get a written appraisal by an expert and a receipt from the charity.

Can you claim depreciation on equipment in storage? Many physician-veterans are puzzled over this one. It might seem logical to re-evaluate your equipment and furniture to compensate for the depreciation you did not claim while they were gathering dust during the war. But the law allows a deduction for depreciation only on equipment actually *used* in a trade or business. Legally, equipment in storage is not being used. So, logical or not, the re-evaluation process is not allowed.

Are insurance proceeds from theft losses taxable? Money paid to you by an insurance company above the adjusted cost of property stolen is taxable. But when an insurance company *replaces* stolen equipment, there is no tax.

You are allowed as much time as you need to replace property. But if shortages make immediate replacement impossible, notify your local revenue collector and earmark your insurance proceeds for this purpose.

You cannot anticipate collection of insurance funds. Buying new equipment out of your own pocket and then using the insurance check to reimburse yourself sounds reasonable. But it isn't allowed for tax purposes. The same money paid to you must be used to purchase the new equipment.

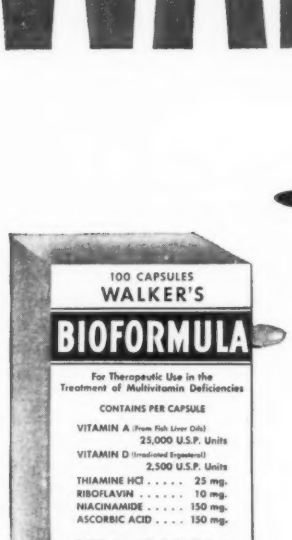
Can interest paid on a loan be deducted? As a rule, yes. But borrowing from a creditor to pay interest due him on a prior loan is not deductible. If you owe interest for a loan on an insurance policy, for example, you can tap the company for money to pay that interest. But you cannot deduct that payment from your income tax. Borrowing from Peter to pay interest to Paul is another matter; in that case, you can deduct for the interest payment.

How do you compute the tax on lump-sum payments? Every now and then you receive a windfall when a patient suddenly decides to settle a long-standing account. Under the law you can pro-rate such payments over the period during which services were rendered. But there are catches. (1) The lump-sum must equal at least 80 per cent of the total bill. (2) The period involved must be at least thirty-six months (there is no maximum time limit).

Spreading your income in this fashion decreases the surtax for the current year. But you are not compelled to spread it. Unless the method will reduce your total payment, it is obviously best to forget it.

—C. K. MARION, LL.B.

WALKER



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People Seek Better Means of Selecting a Physician

Directories giving qualifications of doctors may be answer

It's no secret that laymen often have difficulty in choosing a family physician. Naturally, the bigger the city the bigger the problem. Not only is there a wider choice of M.D.'s, but there are more cultists confusing the issue. Recent publicity in consumer magazines has drawn attention to the laymen's difficulty in learning his doctor's professional qualifications. Here, then, is another medical public relations puzzler.

An investigation made by this magazine, as well as research by other organizations, has made it clear that thousands choose their doctors by hit-or-miss methods, and frequently fantastic reasons. Women, who often do the choosing for the family, have sometimes selected a practitioner because they liked his looks, his voice, or even the sound of his name. Many have relied solely on the recommendation of a neighbor. Seldom is selection based on authentic knowledge of the man's professional standing.

When persons are asked why they allow themselves to be fooled by quacks and faddists, they usually blame the medical profession. "How are we to know who's good and who isn't?" they say. "What else can be expected when doctors themselves provide no other source of information except the biased opinions of their patients? If we look in a telephone directory, we merely find a list of names, all unfamiliar." They might add: "Even in localities where a doctor is allowed to insert a personal 'card' in the classified section of the directory, the card gives only name, phone number, and office hours; or it may carry some such medical term as 'physiotherapy' or 'genitourinary,' which only perplexes us. The great majority of us have never even been told to rely on the local medical society or a good hospital for assistance in finding a doctor. No wonder we ask our neighbors and friends to recommend somebody!"

According to some physicians the problem boils down to this: Nowhere today can the average layman readily obtain authentic, impartial information about a doctor's training and experience. When the G.P. is chosen more or less blindly, he cannot expect the family to have the same confidence in him that it would have if his qualifications were known in advance. In other words, patient as well as doctor suffers.

Few specific remedies have been suggested. Most physicians feel that the problem is one for the

medical societies to solve; that the societies must find some practicable way of making legitimate, factual information available to the public.

Several years ago, a physician suggested in this magazine that county medical societies publish local directories. "Each directory," he wrote, "should supply full details about every local physician: his name, age, address, telephone number, office hours, specialty (if any), medical school, indication of specialty-board approval (if certified), number of years in practice, languages spoken, hospital connections, medical society and similar professional affiliations, post-graduate work completed, scientific honors received, and other pertinent data. Space should also be provided for explaining (1) medical terms used in the directory, (2) the functions of the various types of specialists, and (3) what membership in the various professional organizations means.

"Local business and professional directories now available are not much help to the layman in choosing a doctor. Moreover, they are not widely circulated. Every household should have a ready-reference guide of the type here suggested. Copies should also be distributed to hospitals, clinics, drug stores, libraries, clubs, parish rectories, and other centers of information.

"The advantages are evident: A directory of this kind would help to steer people away from cultists and quacks. It would help to offset the fraudulent advertising of such persons. It would afford blanket publicity for all reputable physicians—publicity which no individual practitioner can ethically obtain. It would prove a stimulus to the average doctor to keep abreast of professional progress, and it would give those who make the effort a legitimate way of making the fact known."

Many people cannot distinguish between an oculist, an optician, and an optometrist; between a dentist and an orthodontist; and between a chiropractor and a chiropodist. A properly prepared directory would, it is held, correct much of this confusion.

In planning a directory, some thought would naturally be called for on one major point: whether the physician's usual fee for an office and house visit should be mentioned. Some doctors would oppose the idea, of course; others have often pointed out that a prospective patient's greatest concern is likely to be, "What will it cost?"

"Unless he knows what he is getting into," says one physician, "such a patient will generally put his $2 into patent medicines which the radio announcer has told him bring quick results. By the time the doctor sees him, an operation may be indicated."

Another takes the stand that collections are much easier when the patient knows in advance what his initial visit will cost. "Three-dollar patients will pay a three-dollar doctor much more quickly than they'll pay a five-dollar man," he argues.

But inclusion or exclusion of the fee is secondary to the more important over-all issue: Should we have local directories published under medical-society auspices? A growing number believe the answer is "Yes—and the sooner, the better!"

—NELSON ADAMS

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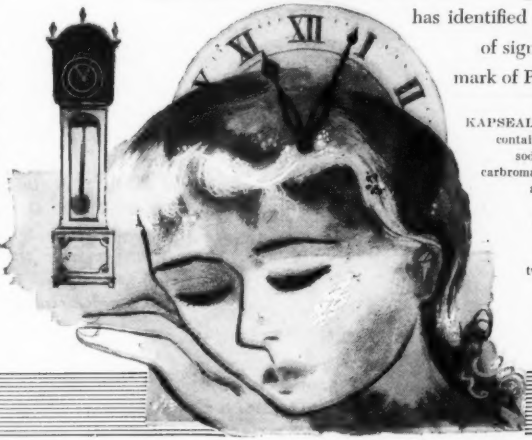
"At hour of sleep"

—an important hour for sedative-hypnotic medication be it on the ward or in the home—an hour for **KAPSEALS CARBRITAL.** For the sleepless, restless, tense or anxious patient, **CARBRITAL** affords prompt sedative action and favors natural sleep without residual depression. One **KAPSEAL CARBRITAL** (*hora somni*) is the usual hypnotic dose, providing the effective combination of pentobarbital sodium and carbromal. **KAPSEALS CARBRITAL** is another contribution to the comfort and well-being of the sick that for the past 80 years has identified as a symbol of significance the mark of Parke-Davis.



KAPSEALS CARBRITAL contains pentobarbital sodium 1½ gr. and carbromal (bromdiethylacetylurea) 4 gr. As a sedative-hypnotic, one to two Kapseals; preoperatively, two Kapseals two hours prior to scheduled hour.

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MEDICAMENTA VERA

The Newsvane

Hope Springs Eternal

Bob Hope's press agent denied last month that the comedian would co-star with Bing Crosby in a new motion picture, "The Road to Mayo Clinic." He conceded, however, that radio's top wisecracker had been cited as a "great healer" by the physicians' fraternity, Phi Delta Epsilon, because of his work in entertaining wounded American soldiers.

A scroll commemorating his wartime activities was presented to Hope, *in absentia*, at the fraternity's annual convention. Immediately afterward the comedian made an "appearance" in a specially prepared movie short in which he thanked the doctors for the honor they had bestowed on him and then entertained them with a comedy routine.

School Children Write on Medical Practice

Last month the Association of American Physicians and Surgeons initiated a nation-wide essay contest for children in junior and senior high schools on the subject, "Why the private practice of medicine furnishes this country with the finest medical care." Three prizes were offered for the best essays: $1,000, $500, and $100.

County medical societies throughout the nation were asked to cooperate by fostering local contests (deadline, Mar. 30) and by sending the three best essays received to the state medical society (if it is participating) or directly to the AAPS at 11 South La Salle Street, Chicago 3, Ill., not later than April 30.

National winners will be selected by a committee consisting of an educator, a layman, and a physician, all of national prominence. Prizes will be awarded about the middle of May.

Higher Insulin Cost Hit by Diabetics

A 50 per cent increase in the retail price of insulin recently brought widespread protests from diabetics, who called the rise "inhuman" and "merciless." Producers of the pharmaceutical, regretful for the necessity of advancing its price, replied that the cost of cattle and hog pancreas had risen "fantastically," and that the 50 per cent rise represented only a part of increased costs.

Diabetics were voluble in their protests. One told the Newark (N.J.) Star-Ledger that the increase was a "shocking instance of price gouging" and that in effect it notified "diabetics with one foot in the grave to 'pay the price or else.'"

A producer denied such intent. "The drug industry," he said, "has always kept insulin a short-profit item because it means life to thousands. In the past twenty-five years,

its cost has been reduced thirteen times, in keeping with this policy." There was no telling, he said, how long the new price would be in effect, but he added that he hoped it would be "temporary—very temporary."

'Abject' G.P. Seen Harming Himself

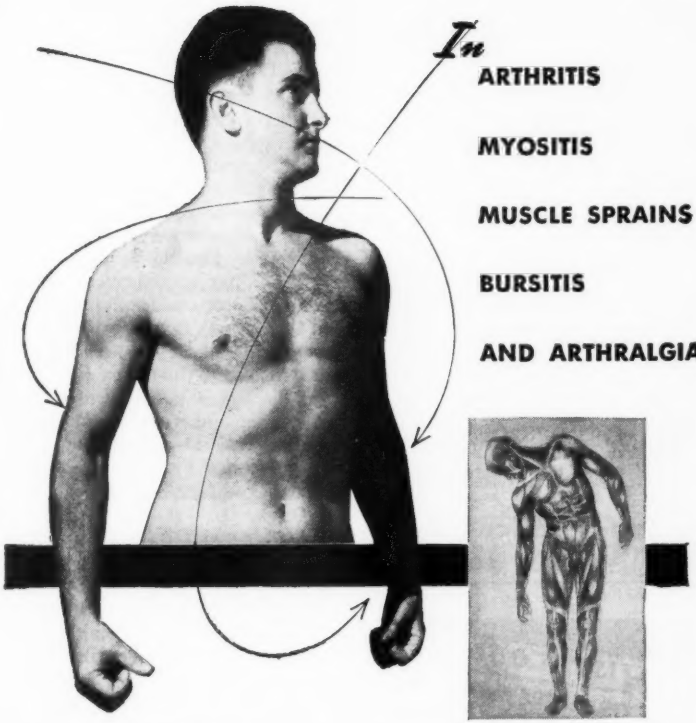
Will the general practitioner continue to play an important role in medicine, or will he be supplanted eventually by the specialist? The profession should do some serious thinking on the subject, says Dr. Ralph A. Johnson of the Detroit Medical News, if it is to answer intelligently the assertion that the G.P. has no place in modern medicine. This statement, he declares, is frequently made by those who favor group practice in conjunction with Federal compulsory health insurance.

The "abject" attitude of G.P.'s actually helps spread such a concept, says Doctor Johnson. "A feeling of inferiority is prevalent among them," he adds. "It is not modesty, it is not shyness, it is not bashfulness—it is a craven, apologetic, deprecating attitude."

New Taft-Fulbright Bill in Senate

Into the Congressional hopper a month ago went the Taft-Fulbright Bill (S. 140), calling for a Department of Health, Education, and Security. This is a modified version of the same two Senators' S. 2503 of last year.

The new bill would lump all Gov-



In

ARTHRITIS

MYOSITIS

MUSCLE SPRAINS

BURSITIS

AND ARTHRALGIA

OBJECTIVE IMPROVEMENT may be achieved through the beneficial influences exerted on the pathologic processes by the active hyperemia induced by a Baume Bengué massage.

SUBJECTIVE IMPROVEMENT is evidenced by a comforting sensation of warmth and relief of pain which may result from the combined local and systemic effects of Baume Bengué.

Percutaneous absorption of methyl salicylate not only reinforces the topical effects of Baume Bengué but can enhance other systemic measures used to combat the underlying disease processes. The proof of the systemic effects of such preparations was established by the fundamental work of Moncorps, Kionka, Hanzlik, Brown and Scott.

Baume Bengué
ANALGESIQUE

Baume Bengué provides 19.7% *methyl salicylate,* 14.4% *menthol in a specially prepared lanolin base.*

THOS. LEEMING & CO., INC., 155 E. 44TH ST. N.Y. 17

ernment offices operating in these fields under one Cabinet-rank Secretary. The health division of the proposed department would be administered by a $12,000-a-year Under-Secretary. Senators Taft and Fulbright stipulate that this post be filled by a licensed doctor of medicine appointed by the President. Under his cognizance would be the U.S. Public Health Service, the Food and Drug Administration, and a Federal Board of Hospitalization.

S. 140 stresses that the objectives of the proposed Department "shall be carried out to the fullest possible extent through state and local agencies, public and voluntary." How much the Secretary of the department got to spend would depend on Congress.

Plan Study of Atom's Effect On Health

A $3 million uranium pile near Bethesda, Md., to be used in testing the atom's effect on health, is called for in a report now in the hands of the U.S. Atomic Energy Commission. The uranium pile is planned as the core of a national radiation institute that is being urged by the U.S. Public Health Service and by the Bureau of Standards.

Said a spokesman for the bureau: "This project would help in getting at radiation values and in establishing the dosages that man and other biological organisms could take. Tests of devices which would protect workers in these fields would then be possible. We cannot afford to repeat the unfortunate incidents of the days when X-rays and radium were in their infancy."

The plan submitted to the Atomic Energy Commission also calls for re-

search on the therapeutic effect of radiation, particularly on its possible effect on cancer. Both fundamental research and experimentation are planned.

Sponsors of the plan are confident that the commission will authorize them to submit it to Congress.

Fewer Hospitals Win ACS Approval

Hospitals that have "permitted themselves to sink into a post-war lethargy" smarted last month under a sharp rap from the American College of Surgeons, which dropped them unceremoniously from its approved list. Although 3,118 institutions drew the ACS imprimatur, the total fell sixty-three short of last year's. Dr. Irvin Abell, ACS president, terms it the first decline in hospital approvals since 1918.

"By withholding approval from a few hospitals," said Doctor Abell, "the ACS is endeavoring to correct certain habits formed in wartime." Among such bad habits he listed: (1) abbreviating medical records, (2) relaxing control of medical staff appointments, (3) omitting medical staff conferences, "which should be held at least monthly," and (4) delegating administrative responsibility to inadequately trained personnel.

Dr. Malcolm T. MacEachern, ACS associate director, stressed the competence of hospital administrators. "There is no longer any excuse for appointing administrators who lack proper qualifications for the post," he said. "The public, for its own protection, should insist that politics be kept out of the hospital field." Dr. MacEachern lashed out at administrators picked because of "political, religious, social, or business standing."

Medical Society Members Get Publicity Cues

Apt advice for medical society members called upon to do publicity work is contained in a deftly written guide being distributed by the Medical Society of New Jersey. It covers just about every means of getting legitimate medical society news into public print.

On "The Care and Feeding of Newspaper Reporters," the guide says: "If a reporter is coming to your meeting, watch for him. Unless you yourself are seated at the speaker's table, make it a point to sit alongside him.

[PLEASE TURN TO PAGE 174]

The First Consideration
IN ASTHMA AND HAY FEVER
is Symptomatic Therapy

THE physician's first consideration in asthma, hay fever, and other forms of allergy, is to alleviate the distressing symptoms of the patient who comes to him seeking relief.

During the past ten years, a steadily increasing number of general practitioners and allergists have been prescribing Novalene Tablets for prompt, symptomatic relief from these conditions.

The effectiveness of Novalene Tablets is due to the synergistic action of these four U. S. P. ingredients:

- ***Ephedrine Sulfate*** **(U. S. P.)** ***0.025 Gm.*** **(gr. 3/8)**
- ***Phenobarbital*** **(U. S. P.)** ***0.015 Gm.*** **(gr. 1/4)**
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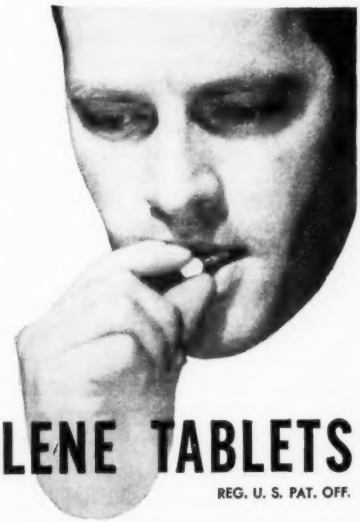
- ***Calcium Lactate*** **(U. S. P.)** ***0.15 Gm.*** **(gr. 2½)**

Novalene Tablets, an ethical preparation, are manufactured under expert pharmaceutical supervision and are advertised exclusively to the medical profession.



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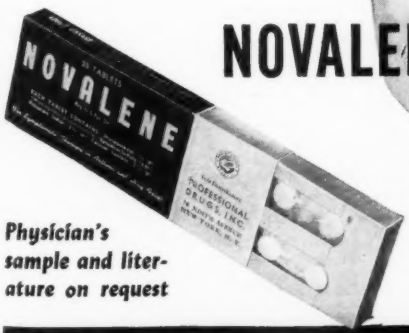

Physician's sample and literature on request

● Novalene Tablets are stocked by leading wholesale drug houses and ethical pharmacies. They are supplied in packages of 25 and 100 tablets, on prescription. Special package of 500 tablets is available for hospitals and allergy clinics.

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"Don't bend over during the talk to give him whispered interpretations. He knows more about medical terminology than you think he does."

Some excerpts on preparing releases: "Reread all your notes, then select the most interesting statement the speaker made. Use this as the opening sentence, and follow that with the usual 'who, when, and where' data . . . Medical words should be translated into lay English even at the risk of slightly blurring the scientific accuracy of the term, provided the meaning is not distorted . . . As a general rule, methods and results of treatment are more important for a news release than are pathology or symptomatology." Pertinent tips are included on distribution of the release and on photographs.

The guide ends with an admonition: "Do not feel hurt if less than half your release gets into the newspaper. If you can get any mention at all, even only a few lines, that's a tribute to your work. If you feel that the editor has badly altered the emphasis of your release, remember that when it comes to gauging public interest, he knows what he's doing. Keep him fed with honest, compact, interesting copy and he will be fair with the medical society."

Stock Trading Well Below '29 Pitch

If physician-investors are typical of other stock owners, they are veering further and further away from stock speculation. At least that's the trend crystalized in a recent sum-

For the Physician's Prescription Only

I.V.C ANNOUNCES PHENO-BEPADOL

Sedation and nutrition join hands in IVC's newest product, "Pheno-Bepadol." As a sedative, it is quick and efficient; the nutritive elements assure a minimum liability to side reactions. Particularly desirable in many functional digestive disturbances (such as neuroses, vomiting of pregnancy and diarrhea), "Pheno-Bepadol IVC" is particularly beneficial to patients suffering from simple insomnia, dull worry or apprehension. It helps to control nervous symptoms and produces the benefits of sedation. Available at most Druggists *on your prescription only.*

PHENO-BEPADOL FORMULA: Each teaspoonful (4cc.) contains: ¼ grain Phenobarbital, 1 mg. Thiamine HCL, 0.5 mg. Riboflavin, 5 mg. Niacin Amide, 0.3 mg. Calcium Pantothenate, 0.15 mg. Pyridoxine Hydrochloride. DOSAGE: "Pheno-Bepadol IVC" facilitates easy adjustment of dosage graduation to the intensity of reaction desired.

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Meprane

an entirely new and exceptionally potent synthetic estrogen for oral administration.

Meprane is one of the most important advances in estrogenic therapeusis. Literature and a supply of Meprane for clinical trial are available to physicians.

REED & CARNRICK

INDIVIDUALLY WRAPPED FOR PROTECTION

Each Meprane tablet is individually protected in its own airtight, cellophane compartment—a pharmaceutical wrapping which safeguards your Meprane prescription up to the time of ingestion.

The brilliant synthesis of Meprane—3,4-bis-(m-methyl-p-propionoxy-phenyl) hexane—culminates 8 years intensive research for a clinically dependable synthetic estrogen free from the disadvantages of diethyl-stilboestrol. The economy of synthetic estrogenic therapy is now available to physicians without the hazards of patient discomfort and imperfect relief of menopausal symptoms.

OUTSTANDING ADVANTAGES

- Relieves menopausal symptoms promptly.
- Restores sense of well-being.
- Unpleasant reactions virtually unknown.
- Exceptionally economical.

IMPRESSIVE CLINICAL BACKGROUND

Comprehensive clinical studies by prominent gynecologists attest the estrogenic potency and dependability of Meprane.

Prompt relief of menopausal symptoms was reported in a large series of cases, patients usually experiencing partial remission of symptoms during the first days of treatment.

Hot flushes, chills, vertigo and such psychic symptoms as emotional instability, irritability, melancholia, weeping, and morbid worrying, which often threaten domestic tranquility and social relationships, are relieved by Meprane.

Unpleasant reactions are virtually unknown.

INDICATIONS: The menopausal syndrome and other clinical manifestations of hypoestrinism.

DOSAGE: In the menopause, initial therapy—1 tablet t.i.d. after meals; maintenance therapy—1 to 2 tablets daily. Dosage for other conditions is available on request. The relatively low dosage schedule reflects the oral potency of Meprane.

PACKAGING: Boxes containing 30 and 100 individually wrapped tablets.

eprane • FOR MENOPAUSAL WELL-BEING

XUM

mary by L. O. Hooper, Boston investment broker.

Says Mr. Hooper: "It has often been said that stocks are 'made to buy and sell,' rather than to hold. If this is true, the public certainly is not convinced. In standard stocks, the annual turnover in ownership is often less than 10 per cent of the outstanding shares. In other words, 90 per cent of the holders of standard stocks seem to regard themselves as more or less permanent owners, with only an academic interest in day-to-day fluctuations."

New York Stock Exchange figures tend to confirm this trend. They show that in 1929 the turnover of listed stocks was nearly 100 per cent of all shares listed. Last year the turnover was below 21 per cent. Volume of shares traded in 1946 was only one-third what it was in the boom year of 1929.

Cursory Examination Blamed on State

The labor union asserted: "This waitress died of tuberculosis less than a year after she had been examined by a private physician under the food handlers' law. A proper examination would have saved her life."

Washington's state medical association replied: "A thorough physical examination would have indicated the need of treatment. But the state doesn't authorize complete physical examinations, nor will it pay for them. The private physician may feel that a chest X-ray is highly desirable, but he cannot force the food handler to undergo such an examination or to pay for it. If the state is concerned with the lives of hundreds of thousands of individuals who will be exposed to disease, it should provide for thorough examination of all food handlers."

Death Takes Reverse Rip Van Winkle

A medical enigma died a month ago: a man who declared that he had never slept a single moment. Doctors who had observed Albert Herpin of Trenton, N.J., could report only that no one had ever seen him asleep until, at the age of 95, he lapsed into unconsciousness and died at a local hospital. Previously he had been a patient on four occasions.

Herpin lived alone in a shack that contained no bed; he said he got all the rest he needed while sitting, wide-awake, in a rocking chair. The

aged man liked to chuckle over a vigil allegedly undertaken by four doctors, half a century ago, to check on his claim that he never slept. The attempt was abandoned, said Herpin, because the doctors couldn't stay awake.

Medical Students Aid the Blind

Two medical students, Arthur DiDea of Washington University and Hilda Laufer of Syracuse University, have been revealed as co-inventors of the so-called "pocket radar" set that enables the blind to avoid obstacles. The device sends out a radio beam that is reflected by objects in front of the user and sets off warning sounds in a headphone. It strengthens the natural aptitude, often developed by the blind, to "hear" obstacles in their path through the reflection of sound.

Mr. DiDea, Miss Laufer, and a third student, Victor Tworsky, developed the instrument while attending the College of the City of New York.

'Cuddle Those Babes,' Brady Advises

The daily "Babes Behind Glass" show that hospitals put on has drawn harsh words from Dr. William Brady, syndicated medical columnist. Scoffing at "all the newborn infants in their bassinets lined up behind a plate-glass window," Doctor Brady lets it be known that he doesn't think much of the "white-enamel antiseptic era." To him, the pageantry of "the student nurse, wearing the imposing 'antiseptic' costume with mask to match, going from one baby to another, carrying

heaven knows what infection on her hands," is strictly from Culver City.

Says Doctor Brady: "Bunching all the infants together like that exposes them to whatever infection any one of them happens to have. A baby is a human being, not a piece of machinery to be controlled by clockwork, schedule, or rigid formula. A baby should be petted, cuddled, loved, and catered to by mother, father, grandma, grandpa, big sister or brother, as occasion may require."

Doctor Brady's occasions apparently don't require a hospital. He concludes by remarking that "In my opinion, home is always the safest place to have a baby."

Connecticut Endorses Commercial Plan

The highly controversial "Wisconsin plan" of prepayment sickness insurance gained another adherent a month ago when the Connecticut State Medical Society announced it was working out a state-wide program with five commercial insurance companies. The companies will offer a number of so-called "single-package" policies, covering medical care and hospitalization.

With benefits on a straight indemnity basis, the plan will provide for 100 per cent free choice of physician, said Dr. Cole G. Gibson, president of the society. He added that both employed groups and individuals would be enrolled, premiums varying according to benefits offered, size of family, and contribution of the employer. It was not revealed when the program, to be known as Connecticut Medical and Hospital Care, will be submitted to the AMA for acceptance as a component of its national network of prepayment organizations.

Health Work Fitted to Need of Area

Indiana is decentralizing its public health activities by establishing five area offices, each autonomous and under the direction of a state deputy health officer. The aim is to attack problems of sanitary engineering and communicable disease that are more easily solved by on-the-spot administration. Each unit will have a medical director, sanitary engineer, consultant nurse, supervising nurse, health education consultant, venereal disease investigator, milk sanitarian, food and drug sanitarian, and administrative assistants. Local health officers will retain their authority, the state unit acting primarily as consultant.

Contraceptives Get No Acceptance Seal

AMA requirements for acceptability of mechanical contraceptive devices have been published by the Council on Physical Medicine. Medical evidence in support of a device will be accepted, it says, only from

physicians with special experience in the field of contraception or obstetrics and gynecology.

The council has prepared detailed standards by which the efficacy, harmlessness, design, and shelf-durability of a product will be judged. In addition, it makes a number of stipulations governing advertising, including an injunction against any statement, direct or indirect, that the device may be chosen without the assistance of a doctor.

The council says it will publish the results of its investigations of contraceptive products but will not permit use of the AMA seal of acceptance.

'Victims' Praise Bogus Surgeon

Allied occupation authorities in Germany have been quietly rechecking the credentials of physicians, especially those with hospital posts, as the result of a widely publicized blunder. In Baden, a year ago, French officials (1) dismissed a renowned surgeon from his hospital position because he had been a Nazi and (2) unwittingly replaced him with an impostor whose actual qualifications consisted of one semester of medical school and some first-aid experience in the German Army.

In a year, the bogus surgeon operated on hundreds of patients—the exact number has not been disclosed—of whom thirty died. His patients included French officials who disdained entering their own military hospitals. Meanwhile, the surgeon whom the quack succeeded earned his living as a street cleaner.

Recently, the imposter was arrested, with much attendant public-

ity throughout the Saar. Particularly embarrassing to both French authorities and German doctors was a flood of letters from former patients of the bogus surgeon, most of them praising his work highly. Some writers ventured the opinion that his mortality rate was "no higher" than that of real surgeons. One newspaper asked editorially just how "saving lives" could be deemed immoral, even if the means were illegal. Nevertheless, the phony surgeon went to jail. He was replaced by his predecessor.

Newsmen Ask Why M.D.'s Don't 'Cooperate'

Forty city editors, representing the nation's leading newspapers, sat down recently with a group of well-known physicians. They had gathered at the American Press Institute, at Columbia University, to discuss the problem of the doctor in the news. Among other things, the editors wanted to know:

"Why do doctors seek anonymity in news stories?" Because of ethical considerations, the editors were told.

"Why do doctors shield newsworthy patients from interviewers or photographers?" Generally, replied the physicians, because exposure to newspaper men might have a bad physical or mental effect on them, hindering their recovery.

"Why are men in medical research so reluctant to discuss their work or their discoveries?" First, it was said, because garbled reporting misleads the public; second, because competent scientific bodies, such as the AMA, must first assess new drugs or new therapeutic procedures.

Dr. Currier McEwen, dean of the New York University College of Medicine, told the newsmen that the publicity problems of reporters and doctors might be greatly reduced if more medical societies were to establish information bureaus that would make information quickly available and would promptly check news stories for accuracy.

Sees Bill Collectors Creating Ill-Will

The medical profession should drop the services of the commercial bill collector, says Rollen Waterson, and the sooner the better. Mr. Wat-

petrolatum to promote optimal conditions for burn healing...

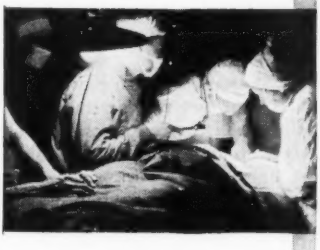
'VASELINE' PETROLEUM JELLY
is the world's leading brand of
PETROLATUM U.S.P.

With normal nutrition and absence of infection, the burned surface heals.

To prevent potential infection, and thus promote optimal conditions for burn-healing, prompt covering of the wound is imperative . . . with a dressing impervious to infection, non-injurious to cells, non-adherent to the burned tissue. [1, 2, 3]

Now . . . as a result of civilian disaster and burn tragedies of the war . . . a new treatment for burns has been developed.

In addition to plasma, and chemotherapy internally or intravenously,[1] burn surfaces are promptly covered with dressings impregnated with petrolatum. With these non-adherent dressings, wounds can be left to "rest" undisturbed for days, without the necessity for frequent changes of dressings...without the accompanying re-exposure of the burn surface to infection, too.



'Vaseline' Petroleum Jelly dressings, non-injurious to cells, protect against surface infection from the air . . . help relieve pain from exposed sensory nerve endings...promote optimal conditions for healing of the burn surface.

'Vaseline' Petroleum Jelly is available in tubes and jars at drug stores everywhere. 'Vaseline' Borated Petroleum Jelly in tubes only.

Vaseline
REG. U.S. PAT. OFF.
PETROLEUM JELLY

1. J.A.M.A. 125:536-543 (June 24) 1944
2. J.A.M.A. 125:612-616 (July 1) 1944
3. Ann. of Surg. 117:885 (June) 1943

MADE ONLY BY CHESEBROUGH MANUFACTURING COMPANY, CONS'D, NEW YORK, N.Y.

erson, executive secretary of the Alameda County (Calif.) Medical Society, believes that collection agencies have seriously jeopardized medicine's position in public esteem. "The commercial collector," he says, "represents the cold, impersonal, and inflexible economy of the market place. Medicine, by its employment of his services, is branded with the same stigma of heartless commercialism that attaches to his calling."

Mr. Waterson suggests that the commercial collector be replaced by the medical society business bureau. The latter, he says, has been successful wherever tried. He cites the Alameda society's bureau as an example.

"It was established," he says, "to treat the entire problem of the economic ills of the individual doctor-patient relationship. Its basic principles are the *prevention* of delinquencies and the restoration and preservation of good doctor-patient relations at their point of inception—the doctor's office."

The bureau's employes, says Mr. Waterson, are trained to win friends for the doctor as well as to recover money for him. They make no threats and employ no aggressive measures, except with known deadbeats. Ordinarily, the bureau's first step in collection is the dispatch of a statement. The particular statement used, says Mr. Waterson, would be considered "heretical" in commercial circles, for it contains a note to the delinquent patient that he will not be required to pay more than he can afford in settling the account.

The patient's ability to pay is determined in an interview. Often the bureau asks the doctor to reduce his fee or to accept part payments over a prolonged period. In no case, says the Alameda secretary, has a physician ever declined to cooperate. "The renewed feeling of faith and trust in the doctor—and in the profession—which this creates is obvious," he adds.

The bureau is said to have been so successful that commercial agencies have called its activities "socialized collections." The bureau replies that agencies, as a group, have never attempted to correct the conditions that cause delinquencies. As a matter of fact, it says, medical accounts are rich plums for them because of the poor business methods employed in most doctors' offices. It is these conditions that the bureau seeks to clear up, by providing competent auditing, accounting, and billing services.

. . . to relieve the strain of CHRONIC IRREGULARITY

WHEN frequent aberrations of the menses suggest that normal function has overstepped the bounds of physiologic limits—the physician is often confronted with a condition which proves highly distressing to the patient.

For such cases (as in amenorrhea, dysmenorrhea, menorrhagia and metrorrhagia), many physicians rely on Ergoapiol (Smith) as the emmenagogue of choice. By its unique inclusion of all the alkaloids of ergot (prepared by hydro-alcoholic extraction), and synergized by the presence of apiol, oil of savin and aloin—Ergoapiol provides a balanced and sustained tonic action on the uterus, affording welcome relief in many functional catamenial disturbances. It produces a desirable hyperemia of the pelvic organs, and stimulates smooth, rhythmic uterine contractions. Ergoapiol also serves as an efficient hemostatic and oxytocic agent. Dosage: 1 to 2 capsules 3 to 4 times daily.

Write for your copy of the new 20-page brochure
"Menstrual Disorders—Their Significance and Symptomatic Treatment"

Ergoapiol is supplied in ethical packages of 20 capsules.

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Ethical protection mark, "MHS" visible when capsule is cut in half at seam.

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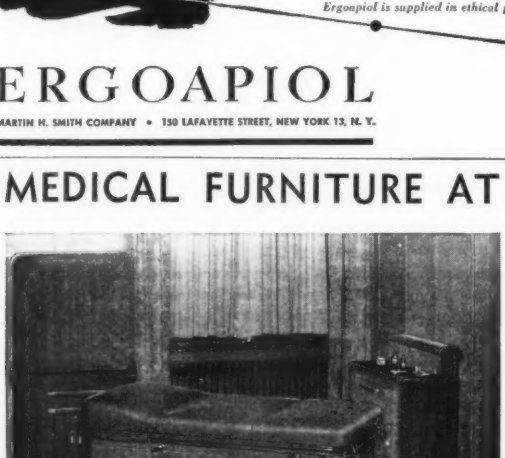

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